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PUBLIC HEALTH CHALLENGES IN OUR NATION'S CAPITAL

HEARING

BEFORE THE

OVERSIGHT OF GOVERNMENT MANAGEMENT, THE FEDERAL WORKFORCE, AND THE DISTRICT OF COLUMBIA SUBCOMMITTEE

OF THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS UNITED STATES SENATE

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PUBLIC HEALTH CHALLENGES IN OUR NATION'S CAPITAL

TUESDAY, MAY 19, 2009

U.S. SENATE,
SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT, THE FEDERAL WORKFORCE, AND THE DISTRICT OF COLUMBIA,
OF THE COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:48 p.m., in room SD–342, Dirksen Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Subcommittee, presiding.

Present: Senator Akaka.

OPENING STATEMENT OF SENATOR AKAKA

Senator AKAKA. This hearing will come to order.

Good afternoon, everyone. Thank you for joining us today as the Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia meets to evaluate the current state of public health in the District, examining the health challenges facing its residents, and the steps being taken to respond to those challenges.

D.C. has the highest rate of HIV/AIDS in the Nation, a distinction that is cause for great concern. The 2008 HIV/AIDS Epidemiology Update concluded that at least 3 percent of District residents live with HIV or AIDS. More than one-third of those infected are unaware of their HIV status. Data from the Centers for Disease Control (CDC) confirm that infection rates among D.C. residents have remained among the highest in the Nation for a number of years now. These figures also show HIV infection cutting across all demographics, highlighting the need for initiatives designed to reach people of every race, income level, and orientation.

The HIV statistics have not been all negative. Overall, the District's publicly supported HIV testing increased by 70 percent from 2007 to 2008. In 2007, only one baby was born with HIV in the District compared to 10 babies in 2005, indicating that pregnancy initiatives are taking root.

These improvements are due in no small part to the D.C. Department of Health (DOH) and HIV/AIDS Administration, which have focused their efforts on increased testing and prevention, working with the D.C. Public Schools to offer education and sexually transmitted disease (STD) testing. Also in place is a drug assistance pro-

gram under which some residents receive free medication to treat their HIV.

While HIV/AIDS Administration initiatives offer promise, there is still much work to be done, especially in the area of testing. If residents do not know their HIV status, they cannot seek treatment and they may be at greater risk of spreading the virus to others.

In addition to HIV/AIDS, D.C. has a disproportionately high chronic disease burden compared with the rest of the Nation. One-third of D.C. residents suffer from heart disease, diabetes, or kidney disease. These diseases share common risk factors including high blood pressure and being overweight. In 2007, 55 percent of D.C. adults and 18 percent of youths were obese or overweight. The District must promote proper diet and exercise to lessen the burden of chronic disease.

Late last year, Mayor Adrian Fenty announced the Chronic Care Initiative to increase chronic disease testing and treatment. The Initiative also aims to address common risk factors by promoting a healthy lifestyle.

I want to highlight two work groups focused on addressing obesity and preventing health risks early in life. The D.C. Obesity Work Group is charged with creating a citywide obesity action plan to be released later this year. The School Health Work Group focuses on providing healthier food options, especially to students in the D.C. Public Schools.

The DOH participates in the Obesity and School Health Work Groups and has developed the Child Health Action Plan, which addresses a range of health risks including obesity and encouraging students to make healthy and informed decisions. I am pleased the DOH recognizes the need to prevent health risks early in life.

It will not be easy to ensure that people seek routine testing and primary health care, especially when they do not have insurance or qualify for special assistance. Nevertheless, we must act to slow the growth of all diseases and to promote health. I have long supported programs to prevent, detect, and more effectively treat chronic diseases and medical conditions. In addition, I have led efforts to improve access to quality health care for indigenous people as well as racial and ethnic minorities who often lack access and suffer disproportionately from certain diseases such as diabetes.

The DOH cannot overcome health challenges alone. It is important to work with community organizations to reach as many people as possible. I am encouraged by partnerships between the DOH and community groups and hope more alliances are formed to address all of D.C.'s health issues.

Today's hearing is meant to foster an ongoing dialogue on these important issues as we gain a greater understanding of D.C.'s health challenges and possible solutions to those challenges. I look forward to hearing from our witnesses today.

I would now like to welcome today's witnesses to the Subcommittee: Dr. Pierre Vigilance, who is the Director of the D.C. Department of Health; Dr. Shannon Hader, who is the Senior Deputy Director of the HIV/AIDS Administration; and Dr. Raymond Martins, who is the Chief Medical Officer at the Whitman-Walker Clinic in D.C.

It is the custom of this Subcommittee to swear in all witnesses. I would ask all of you to stand and raise your right hand. Do you swear that the testimony you are about to give this Subcommittee is the truth, the whole truth, and nothing but the truth, so help you, God?

Dr. VIGILANCE. I do.

Dr. HADER. I do.

Dr. MARTINS. I do.

Senator AKAKA. Thank you very much. Let the record show that the witnesses responded in the affirmative. I want the witnesses to know that while your oral statements are limited to 5 minutes, your entire statements will be included in the record.

Dr. Vigilance, please proceed with your statement.

TESTIMONY OF PIERRE N.D. VIGILANCE, M.D.,[1] DIRECTOR, DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH

Dr. VIGILANCE. Thank you, Chairman Akaka, distinguished Members of the Subcommittee. I am Pierre Vigilance, and I am the Director of the District of Columbia's Department of Health. I am honored to testify before you today on public health challenges in the Nation's capital, and I am pleased to be joined by Drs. Hader and Martins as we discuss the HIV/AIDS epidemic in the District as well. Thank you, Chairman Akaka, for your significant work and your service in the health care arena. It goes to some extent to show how dedication to this particular field has benefited us significantly, and hopefully today's testimony will assist you in your work.

Public health prevents illness, it promotes wellness, and it protects the people from health threats. Public health saves lives, and at a time when health care reform is front and center in our national policy debate, many agree that public health is the missing factor that can lead to cost-saving solutions needed to save our Nation's health. Effective public health practice educates people, advocates for the conditions that promote wellness, links people to care, and provides access to treatment.

The District's Department of Health is an agency of 836 staff with an annual budget of $268 million. Our work spans the public health spectrum from oversight, inspection, and regulation of health facilities to emergency preparedness, addictions prevention, community health, and HIV/AIDS. Annually, the department provides immunizations to over 3,600 people. Last year, we facilitated access to care through a network of community clinics that serve some 93,000 people. We investigated 775 communicable disease cases, removed approximately 130,000 potentially tainted needles from the street, and inspected 388 health facilities.

The District boasts a high rate of health insurance relative to similar jurisdictions across the country, with 90.5 percent of our residents being insured but only 20 percent of them indicating that they have a regular source of care. In fact, some 3,000 District residents die each year from preventable causes of death: Heart disease, cancer, cerebrovascular disease, accidents, and HIV/AIDS.

[1] The prepared statement of Dr. Vigilance appears in the Appendix on page 23.

We understand that the reasons for this are a combination of factors affecting lifestyle, including poverty, illiteracy, unemployment, poor health conditions, social inequities that influence access to health care, and other resources that influence health themselves. Behavior plays a part, but all poor health outcomes cannot be attributed to this alone.

The breadth of problems facing our communities require that we partner with our local non-government agencies, businesses, and sister agencies, such as Health Care Finance, Parks and Recreation, Homeland Security, Fire and Emergency Medical Services (EMS), just to name a few.

Obesity is a health challenge to which we have taken a collaborative approach. It is a major contributing factor, as you mentioned, to many chronic illnesses, including hypertension, cardiovascular disease, and stroke. Youth in the District suffer disproportionately from obesity, and our work in the D.C. Public Schools shows that 17.5 percent of D.C. Public School students self-report that they are obese. The Obesity Work Group that you mentioned comprised a number of different community stakeholders, workforce leaders, and others coming together to strategize on ways to combat obesity.

I am fortunate to work for an executive who understands the importance of effective public health. We also work for an empowered City Council, which in 2007 asked us to develop a 5-year strategic plan targeting cardiovascular disease, diabetes, and kidney disease, a plan that serves as a tool for coordinating services to reduce poor health outcomes.

Since the major causes of chronic kidney disease are high blood pressure and diabetes, the Department has funded programs to address risk factors such as blood pressure and blood glucose control. The Cardiovascular Diseases, Diabetes, and Kidney Diseases (CDK) Plan laid the groundwork for the Chronic Care Initiative which will guide our city's service delivery system toward high reliability, high value, and high quality care.

In 2006, nearly $250 million in tobacco settlement funds were dedicated to public health. Initially, funds were directed to cancer, tobacco cessation, chronic disease, and health information technology. We have invested in the consortium of community-based providers to provide a comprehensive tobacco cessation program, and we have also invested significantly in health information technology, a regional health information organization with six diverse community health centers as well as two emergency departments.

In 2007, the Rand Report provided us with a backdrop that will guide our distribution of the remaining tobacco settlement funds, and we have continued to invest in primary and emergency care, and will be investing shortly in a health care facility on the old D.C. General site, as well as in other locations in the city.

We will also be working significantly with the incoming American Recovery and Reinvestment Act funds which will allow us to move some of our health empowerment activities further into the communities that we serve.

Lives can be saved through a very collaborative prevention-focused approach to health and wellness. The significant economic burden of disease requires that we pay particular attention to pre-

vention. More work needs to be done on policies that will impact the root causes of health problems, policies that effectively address food, content and availability, and physical activity opportunities in communities where the health disparities are most pronounced.

More needs to be done to help people understand for what they are at risk. Effecting long-term improvements in health will take concerted effort and time. From the classroom to the boardroom, public health can facilitate the discussion between previously disconnected partners and lead us to living healthier, more productive lives.

Senator AKAKA. Thank you very much for your statement. Now we will hear from Dr. Hader. Please go ahead with your statement. Thank you.

TESTIMONY OF SHANNON L. HADER, M.D., MPH,[1] SENIOR DEPUTY DIRECTOR, HIV/AIDS ADMINISTRATION, DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH

Dr. HADER. Chairman Akaka, Ranking Member Voinovich, and Members of the Subcommittee, I am Shannon Hader, Senior Deputy Director of the HIV/AIDS Administration in the District of Columbia Department of Health. I appreciate this opportunity to present testimony for you on the HIV/AIDS epidemic in the District of Columbia, and my oral testimony will cover highlights about our new statistics, our strategies and initiatives, and, of course, my written testimony covers these topics in much more detail.

Overall, as you mentioned, 3 percent of all District residents in our city are currently known to be diagnosed and living with HIV and AIDS. To put that in context, U.S. Centers for Disease Control and Prevention and the World Health Organization (WHO) have historically defined an HIV epidemic as "severe" when just 1 percent of the overall population is affected. These numbers, as you stated, however, reflect only the people who have been diagnosed with HIV/AIDS. Targeted studies in D.C. show that between one-third and one-half of our residents who are already infected with HIV may be unaware of their infection. In the District, nearly every population group, age group, and ward is experiencing a substantial epidemic.

The District has also one of the most complex epidemics in the world, with all three major modes of transmission at high levels. Among new cases, heterosexual contact is the highest at nearly 40 percent, followed by sex between men who have sex with men at about 25 percent, and injection drug use still at 15 percent.

I am pleased to share some of the promising results of the District's efforts to reduce the disease. Particularly, the District's HIV testing programs have greatly increased timely testing and early diagnosis among residents and have reduced the number of babies born with HIV, as you mentioned in your testimony. In addition to reducing the number of babies born, we have also seen a 70-percent increase in the number of people tested in publicly supported testing from 40,000 in 2007 to over 70,000 in 2008.

The District was actually just recognized by the CDC as one of the top three jurisdictions in the country in expanded HIV testing.

[1] The prepared statement of Dr. Hader appears in the Appendix on page 38.

D.C. nearly equaled both New York City and the entire State of Florida in absolute numbers of persons tested as well as new HIV cases identified.

These achievements are the mark of true committed leadership to reverse the epidemic by our Mayor Adrian Fenty. Our modern epidemic requires a modern response. I can summarize this in Mayor Fenty's directives to me since I started this position, which are essentially go fast, go far, and do not go it alone.

Go fast. The Mayor has repeatedly emphasized a clear urgency for response marked by actions that are not just a flash in the pan, but are focused for a sustained and impactful response. An example of this is our HIV testing program which, as I described earlier, has rapidly expanded and already shown an earlier diagnostic impact in the course of just 2 years, yet is sustainable and scalable. It aims to mobilize our health care system to make HIV as regular a test as blood pressure, blood sugar, cholesterol, and other vital signs tests. In a city where HIV is a common disease, an annual test for HIV must be a standard vital sign for every resident's health.

Go far. The Mayor has directed us to bring the District's response to scale and impact. We are ramping up our enrollment in care and treatment programs. Through marketing and outreach, we have increased enrollment in our AIDS Drug Assistance Program by over 50 percent in just an 18-month period. This is now the highest level ever.

We are also reaching more residents with tools to prevent transmission. The District is one of only two cities with a large public sector free condom distribution program, and we have distributed over 1 million condoms in the past 6 months and are on target to reach 3 million condoms per year. In addition, following Congress' lifting the ban on the use of our own local dollars to support needle exchange, we have implemented comprehensive harm reduction programs which in just the first 6 months have already enrolled 900 people into the services, linking 40 percent of them to detox and treatment services, and removed 130,000 used needles from the street.

The District is also breaking new ground in the country with innovative programs, including a couples HIV testing initiative, expansion of the Parents Matter curriculum, and an evidence-based intervention that trains parents to communicate with their young pre-sexual children that has been very successful elsewhere in the world.

Do not go it alone. One of the cornerstones of our Mayor's directive is to build strong partnerships. In terms of community partnerships and outreach through the Effi Barry Program, we have engaged more than 50 small organizations, many of which who do not designate HIV as their primary mission, to mainstream HIV/AIDS into their daily programming. We are expanding our faith-based partnerships through our Places of Worship Advisory Board, and we have funded an umbrella organization to work with faith leadership of multiple denominations to take on the mantle of HIV.

For young people, we are partnering with D.C. Public Schools in curriculum development implementation, a rollout of voluntary school-based STD screening and treatment, and in offering free in-

formation for STD and HIV, as well as screening and treatment to young people who are in our Summer Youth Employment Program.

I have reached my time limit, so I am going to truncate my oral report. So, in summary, I think there are also many opportunities for us to work even more collaboratively and effectively with our Federal partners, both in coordination of the Federal support for our programs as well as in response to specific requests for funding supplements we have made that will help us not just scale up our programs but to catch up for the years where this response has not been marked by aggressiveness, by evidence base, or by leadership.

Finally, we might have the most complex epidemic in the country, but the current state of our epidemic is now emerging in other urban areas across the country as well. The increase in heterosexual contact is now surfacing in cities like Atlanta and Miami, and many urban areas have hot spots within them that reflect similar patterns and challenges to what is seen just citywide here in D.C.

So we have reached the proverbial fork in the road for the domestic HIV response. The trends in our city's epidemic are now emerging in other urban areas, so turning the tide in the District, right here in your backyard, is an important model for other urban area hot spots as well. We assure you that our leadership, innovation, and capacity are present to return the Federal investment in our city and turn the corner for District residents for the HIV/AIDS epidemic.

Senator AKAKA. Thank you very much for your testimony. Now we will hear from Dr. Martins.

TESTIMONY OF RAYMOND C. MARTINS, M.D.,[1] CHIEF MEDICAL OFFICER, WHITMAN-WALKER CLINIC, AND CLINICAL PROFESSOR OF MEDICINE, GEORGE WASHINGTON UNIVERSITY

Dr. MARTINS. Good afternoon, Chairman Akaka and Members of the Subcommittee. Thank you for inviting me to provide testimony about public health challenges that face the District of Columbia, specifically in regards to HIV.

I am a primary care and HIV physician in the District, which is also where I completed my medical training and I currently reside. I have been the Chief Medical Officer (CMO) of the Whitman-Walker Clinic for the past 15 months. Through our two District health centers, Whitman-Walker Clinic acts as part of the health care safety net in D.C., providing care to the lesbian, gay, bisexual, and transgender (LGBT) community, persons living with HIV, and others who face barriers to care. We provide a primary medical home to more than 3,000 HIV-positive patients. My experiences there, as well as from my previous practices, and recent data and research results form the basis of my comments.

The District of Columbia is in a unique situation with respect to HIV as compared with other cities in the United States. The 2008 HIV/AIDS Epidemiologic Update for the District reported that 3 percent of District residents have been confirmed to be living with HIV. However, random sampling research shows that the number infected with HIV is likely closer to 5 percent. These numbers far

[1] The prepared statement of Dr. Martins appears in the Appendix on page 51.

exceed most cities within the United States and are truly staggering.

A major factor that contributes to this, especially in comparison with other major metropolitan areas, is the increased prevalence of HIV in multiple communities. HIV in the District finds itself in every race, economic status, and social network. Throughout the rest of the United States, men who have sex with men is the predominant mode of transmission for new HIV infections. In contrast, Washington, DC is the only major city in the United States where heterosexual intercourse is the main mode of transmission for new infections.

Why is this the case? According to a recent study, District residents who report being in heterosexual committed relationships are infrequently monogamous and often do not use condoms. This sex outside the relationship, along with the lack of condom use in a population with a high prevalence of HIV, likely explains the increased incidence of HIV in the heterosexual community.

My response to this is three-fold. One, the District should continue an aggressive HIV testing campaign. I think we are all in agreement on that. Two, the clinical guidelines regarding treatment for HIV need to be re-evaluated. And three, health care providers within the District need to increase their own collaborative efforts. And allow me to expand on my recommendations.

First, testing people for HIV early, often, and repeatedly helps to assure that we are focusing our energies. I do not believe we should give up on education, prevention, and behavioral change models; but, I think it would be unwise to focus all resources solely on education and behavioral change. Rather I propose that we should rely on aggressive HIV testing to identify everyone who is HIV positive and change clinical treatment strategies to lessen new infections.

HIV opt-out testing was started in 2007 by the D.C. Department of Health. Through this program, more HIV tests are being performed, and we are catching people earlier in their disease. The District is now diagnosing people with HIV on average before they develop AIDS and any associated complications.

Second, current HIV treatment guidelines recommend following a patient with regular blood tests until their CD4 count falls below 350 and then to recommend initiating antiretroviral therapy. During those years off medications, the patients often have a large amount of HIV in their blood (i.e., a high HIV viral load) and can easily infect others. Alternatively, if we treated patients with HIV medications soon after infection, the viral load should be suppressed to very low levels much sooner, and it would be more difficult for them to transmit HIV to someone else.

Additionally, recent clinical trials have shown benefit to the individual patient when starting HIV medications earlier. This change in public health protocol will only work with the change in guidelines from the International AIDS Society (IAS), the Infectious Disease Society of America (IDSA), the Department of Health and Human Services (HHS), and other agencies. If accumulating data does not support generalized clinical benefit, there should be at least a recommendation specific to the District to offer HIV medications earlier to potentially curb new transmissions.

Third, I strongly believe that one of the only ways we can change the course of the District's HIV epidemic is through a coordinated and aggressive response. Collaboration between local health authorities, universities, research centers, community health centers, and private practices will be critical. Many programs such as the D.C. Center for AIDS Research have focused on increasing grants for HIV clinical and basic research.

One program that should have immediate impact on the HIV epidemic is the D.C. Cohort. This collaboration will allow the District to follow nearly 10,000 clients to better understand the HIV epidemic in real time and the ongoing issues surrounding care, treatment, and survival.

In closing, the 2008 D.C. HIV/AIDS Epidemiologic Update served as a call to action, with much media attention to the increased HIV numbers. However, it appears to have been quickly forgotten. The District would benefit from an aggressive media campaign so the public is frequently reminded of the severity of HIV along with the recommendation for everyone to be tested on a regular basis.

By using the Treatment as Prevention strategy, patients will be started on antiretrovirals earlier in their disease and will be less likely to transmit to others. Through these programs, more individuals will be diagnosed with HIV and will need an expanded HIV primary care infrastructure within the District.

Whitman-Walker Clinic appreciates the leadership of the Subcommittee in holding this hearing, and we look forward to providing whatever guidance or support that we can offer.

Thank you.

Senator AKAKA. Thank you very much, Dr. Martins.

I have a few questions for you all. Dr. Hader, the District has increased publicly supported HIV testing by 70 percent in 1 year. That remarkable achievement was possible in part because the District has implemented HIV Opt-Out testing, where individuals no longer have to request a test but may choose to decline it. Yet the 2008 epidemiology report on HIV/AIDS indicated that more than one-third of D.C. residents who are infected with HIV do not know their status.

How extensively is the Opt-Out testing program used in the District and how could it be more effective?

Dr. HADER. Thank you for that question. Yes, while we are very proud of the gains we have made in expanded HIV testing over the past 2 years, we also know we have a long way to go. The District is one of the first jurisdictions in the country that formalized the policy for routine opt-out testing in medical settings as well as going one step further and said we do not want you to just get tested once, we want you to get tested routinely and repeatedly through your health care provider.

So in translating policy to implementation, our major steps have been in emergency room settings as well as primary care settings, developing the models, and achieving enough results that inform our further scale-up. For example, we have two emergency rooms (ER) out of six that would be useful for routinely testing for HIV. We are on target to expand with the participation of those other four ERs during the next 18 months.

Likewise, we started with one major primary care network, our Unity Health Care provider, that routinely provides services, primary care services to 80,000 District residents to help roll out amongst their 17 main clinics routine HIV testing, and they are the ones who actually developed this fifth vital sign model so that you get offered an HIV test automatically when you are getting your vital signs done. If you say no the first time, your doctor is going to also follow up before you leave and say, "Are you sure you do not want one?" Because we offer it to everyone.

So our goals for this year are to expand those lessons learned in the first primary care network amongst our other Medicaid and D.C. Alliance-funded managed care networks of primary care to get to scale.

Now, what is going to help us achieve these results faster? And I think this highlights that although we have a progressive policy, we have a lot of catch-up to do from people who have not known their status for a long time. So one of the requests we have put into the CDC is actually saying if we have a one-time doubling of our overall budget for HIV testing, we can rapidly get up to scale across our ERs and our primary care networks, as well as continuing to drive demand among clients so that 18 months from now we will have completely doubled our entire results from that one-time investment.

So we hope that we will hear back from the CDC that is a positive investment because without the additional resources, we will keep on track, but we will not get there as quickly.

Senator AKAKA. Well, thank you very much for what you are doing.

Dr. Martins, Whitman-Walker Clinic has long been a part of the community response to HIV/AIDS. I understand that Whitman-Walker has had to adjust for limited resources, high demand for services, and changing demographics of those that you serve.

Will you please describe the steps your clinic is taking to keep pace with these pressures?

Dr. MARTINS. Sure. So, Whitman-Walker, a few years ago changed the way it offered services. As of a few years ago, it was mainly a grant-based organization that only saw patients with HIV, and it was started by the LGBT community here in Washington. At that time it was decided to expand services to the larger community in Washington, and so while continuing to serve its main constituents, it offered services to a larger group.

To me, I like that we have decided to expand our offering because, previously in the older model, if you were in the LGBT community but you were HIV negative, Whitman-Walker really could not help you. We could do some STD testing for you, but we could not be your primary care center.

So now I feel like we are the primary care center for a larger community.

What is true is that finances, as a community health center in an urban environment, are always tough and we have tried not to cut back on any kind of large-scale medical or mental health services. However, we have had to cut back some of the additional services we offer, but keep the medical and mental health ones going strong. That is how we have adjusted to the pressures.

Senator AKAKA. What about the demand for services? Is that overwhelming?

Dr. MARTINS. The demand is always there. We have a large number of new patients; we have a large number of new HIV clients. We have the largest STD clinic in the city on Tuesday and Thursday nights. We see on average 30 to 40 individuals each night, and we have to turn people away because it is so popular. And the sad part of those statistics is amongst those 30 to 40 people, it is not uncommon to have two to three to four new HIV diagnoses each night.

So it is programs like that where I wish we could expand our offerings and offer an additional night a week we could accept more patients, but to do that, we would need additional funding.

Senator AKAKA. Dr. Martins, you mentioned that Whitman-Walker provides primary care services. Can you please explain why it is necessary to focus on a person's overall health rather than focusing only on one particular health risk?

Dr. MARTINS. Sure. So HIV, as a perfect example, with the advent of good HIV medications, people are living for much longer, and perhaps decades longer than before. Those people, due to the medications they are on, the disease itself, and the fact that they are getting older, are at increased risk of getting diabetes, heart disease, and all the things that we predict as a population ages.

So I think to truly be an HIV primary care provider for a person, you would have to look at the whole person and be comfortable with treating the entire individual, because otherwise those diseases will probably kill the person long before the HIV will.

Senator AKAKA. Thank you for your response on that.

Dr. Vigilance, I commend the Department of Health for its many health initiatives and programs, and I also commend you for your work as its director. As you well know, the District faces the challenge of coordinating effectively with a variety of Federal agencies, nearby States, and many local entities to effectively protect public health.

What steps are DOH taking to promote coordination and to minimize waste and miscommunication?

Dr. VIGILANCE. Well, there are a number of different places in which we work very closely, as you mentioned, with local and Federal partners. I think a very good example of a coordinated activity with which we are regularly involved is our emergency preparedness work. Recently, the H1N1 situation that swept the Nation and is still in play, if you will, provided an opportunity for us to work not only as the National Capital Region with our colleagues in northern Virginia and in southern Maryland but also with our colleagues at the CDC and colleagues in other Federal agencies who provided us with guidance and expertise as we needed moving forward. That activity was mirrored by our activities around the inauguration, where we also were very involved with those entities at a time when there was a need for that collaboration.

I think that is a good model for ongoing activity with respect to some other aspects of the Health Department's activity. I know that the HIV/AIDS Administration is very closely involved with not only the National Institute of Health (NIH) but also with the CDC, and the investments in that particular practice are evident.

We have some investments in chronic disease related to the CDC activity that we have around diabetes, for example, but there certainly is a need for us to be a bit more thoughtful about how it is that we can make best use of those partners, not only the obvious partners, but also partners who are in the District that receive funds from those agencies. So we have a lot of other agencies within the District of Columbia, such as academic institutions, that receive funding that we would do well to partner with a bit more effectively around chronic disease. We do some work with them now, but we could do well to do more.

Senator AKAKA. Dr. Hader, I understand that in the past the Department of Health and D.C. Public Schools (DCPS) have not always coordinated effectively. What steps have you taken to improve communication and collaboration with DCPS specifically?

Dr. HADER. Well, for young people, we are partnering with D.C. Public Schools on multiple fronts. First, is on health curriculum, so D.C. Public Schools and the Office of the State Superintendent of Education (OSSE) about a little over a year ago passed health learning standards that included learning objectives on sexual health. Since that time, we have been actively participating in the DCPS school health curriculum to identify, roll out, and develop evaluation processes asking, do kids actually learn this stuff for elementary, junior high, and high school schools? Now, many of these curricula are already in place, but the formalized, multi-school curriculum will be starting in September.

Second, we work directly with the D.C. Public Schools to roll out this innovative, school-based STD screening program for kids. It is both an education, a diagnostic and treatment, but also a transmission interruption program. We have modeled it after New York City and Philadelphia and the objective is to go into schools, diagnose kids voluntarily and confidentially who might not know they have an STD, and treat them rapidly for their infection while we are also providing them information and sharing that information that would be helpful with partners.

In our initial activities there, we have diagnosed STD infection rates between 8 percent and 20 percent on any given day in any group of kids. We have expanded—because of the Mayor's advocacy, we have expanded this program to our Summer Youth Employment Program as well.

Third, through our Community Health Administration, in collaboration with D.C. Public Schools, we support training of all the school health nurses to be able to counsel students effectively on sexual health issues, including STDs and HIV.

So I believe our collaboration has improved dramatically, and we look forward to gaining the results of that collaboration.

Senator AKAKA. Thank you for that response.

Dr. Hader, the Youth and HIV Prevention Initiative was introduced in 2007 and is set to end next year. Please elaborate on what the initiative has accomplished and whether there are plans to extend programs under this initiative.

Dr. HADER. Sure. I think the Youth and HIV Prevention Initiative, as marked by our Youth and HIV Prevention Strategic Plan, has been a fantastic collaboration, and what that initiative did was it brought together the Department of Health along with many of

our youth HIV and AIDS focused service providers from the community to identify not only what the needs were from what the data showed, but what the needs were based on their experience on the ground, and to support the capacity organizations to reach more kids with more useful services. And some of the highlights that came out of that are a lot of the D.C. Public Schools collaborations that I highlighted are direct results of the planning, prioritization, and advocacy of that group. In addition, youth HIV testing has expanded dramatically, and I think the specific numbers are in our written testimony.

Third, one of the things we are very proud of is there has been the development of a specific youth social marketing campaign with one of our youth providers, Metro TeenAIDS, that had direct involvement in young people saying, "Yes, that makes sense to me. I understand it. It will catch my attention," to encourage kids to learn about their sexual health, to ask questions, to get tested, and to really make some, hopefully, safer decisions with respect to their relationships.

Another thing we are very proud about is now that we have got our core service providers delivering more services and more results, we want to expand our circles of influence. So one of the activities we funded this year for the first time was for one of our HIV/AIDS expert youth organizations to work with a whole bunch of other young organizations that were not health-related or HIV-related organizations to be able to mainstream basic information about HIV, sexual health, and where to get more services and information into their day-to-day implementation.

So we have increased funding dramatically through this initiative. We have also increased results, and absolutely I can tell you that the commitment to ongoing youth programming is there. And the end of the first plan will just be the beginning of a new plan, I am quite sure.

Senator AKAKA. Thank you for that response.

Dr. Vigilance, your testimony mentioned the Child Health Action Plan and also states that children in the District are at greater risk of obesity than children in the United States generally. Improving residents' nutrition and exercise habits are critical to reducing chronic diseases. This is especially true for children whose habits are just being formed.

I would like to hear more about the Child Health Action Plan, in particular how it addresses nutrition and exercise.

Dr. VIGILANCE. So there are a number of components to the Children's Health Action Plan, and obesity is just one of them. Another piece that has been mentioned is the sexual health piece of things.

What is interesting and important to remember is that, in order to make good choices, the cornerstone is actually some knowledge. And so education is one of the major pieces of the plan that sort of just assumes that this is about children who are getting educated and educated appropriately with respect for what they are at risk and what it is that they need to do in order to live healthy lives.

But there is some work that is going on right now within the school system with respect to changing the actual food choices that children can have available to them, and some of that work is

going to reap some long-term benefits for us. But we understand that children only spend so much of their day in school; there is a need for environmental changes outside of the school. And so as part of the Obesity Action Plan and the Children's Health Action Plan, too, we have looked at what the environments are in which these children live, especially in some of our poorer neighborhoods, with respect to their food access. When we refer to food access, we are referring to not only the availability of grocery stores in those neighborhoods, but actually the availability of fresh fruits and vegetables, food that is low in fat, low in carbohydrates, etc., and also the availability of that food in the local corner stores. And so the Healthy Corner Store Initiative, while it is separate from the Children's Health Action Plan, definitely affects children's health by making corner stores more aware of the choices that are available to their clients so that children who go into those stores might be able to gain access to something other than potato chips or candy and be able to make use of those stores to buy things that are actually nutritious for them.

Again, this is an education process on the vendor side, and there is an economic development piece to that. But there is also a choice piece on the child's side and having an understanding of what is good for them helps them make better choices.

We understand very well, too, that the Children's Health Action Plan will also influence adults because children come home and influence parents and family members in a particularly special way.

So we want to make sure that the information that we impart to children in schools is something that they can translate and take home and make use of in the home so that hopefully adults change their behaviors as well. Sometimes that is a little more difficult than we would like for it to be, but it is certainly a piece of the pie as we look forward.

So the Children's Health Action Plan is one of a number of different initiatives that come together to try to change not only behaviors and attitudes towards food, diet, and exercise, but also seeks to educate the children and those who the children influence themselves as we try to make people a little bit more healthy from the child's perspective.

Senator AKAKA. Thank you for that response.

Dr. Hader, I highlighted the drop in HIV infections among newborn babies in the District in my opening statement. I commend you and others who have joined in this effort for the progress D.C. has made in prenatal HIV testing, which allows an infected mother to get treatment that greatly reduces the risk of transmission to the baby.

How is the District working toward its goal of HIV testing for all pregnant women?

Dr. HADER. Well, we took an urgent response to that problem of ongoing perineal transmission, and we actually started our intervention at the last opportunity for intervention to prevent mother-to-child transmission, which is the labor and delivery suite. And we started by working with all of our labor and delivery suites to be able to not only recognize that they want to make sure they know a mother's HIV status when she rolls through their door, but if she does not have that in her medical record, to be able to offer an on-

site rapid test while there is still time to intervene with antiretroviral therapy during delivery to prevent transmission to the baby.

So that was our urgent point of intervention, and we have been successful in scaling up from one hospital center that was already doing that to, I believe, some amount of screening and testing in five of our six delivery sites.

Second then is reaching out—and we have been doing this—to all providers, in particular the obstetrician/gynecologist (OB/GYN) providers, including in collaboration with the American College of Obstetrics and Gynecology (ACOG) to fully implement routine screening recommendations not only during the first prenatal visit but also, because we are a highly affected city and per CDC and ACOG guidelines, repeat screening in the third trimester to catch that very rare occasion where someone gets newly infected during pregnancy, but those people we know who get newly infected are much more likely to transmit to their baby.

So how are we going to measure the impact of all those outreach efforts in real time, not just waiting for a baby to fall through the cracks, but know how well are we doing with mothers? We have been working directly within the Department of Health with our Center for Policy and Epidemiology to update the vital registration process so that the information that is reported during the regular vital statistics birth record process includes that information about when the mother was tested and did you have those test results and what action was taken based on those test results. And I think by being able to monitor routinely how much success we are getting in the overall screening and implementation of guidelines will tell us how to target additional technical assistance and efforts for providers or delivery sites that might be falling down on the job.

Senator AKAKA. Thank you for that response.

Dr. Martins, in your testimony, you suggested using treatment as a form of prevention, and you recommend changes to national and international clinical guidelines. If those changes are not possible, how would you recommend D.C. implement a Treatment as Prevention program?

Dr. MARTINS. So I think that program would only work if there was a recommendation from a level higher than the provider to offer treatment earlier. I am not sure if that would be the Department of Health or what would be the most appropriate for the District, because for this to be effective, it would have to get to all the physicians who are in private practice, who are at the community health centers, at the universities, where everyone is being treated. Current guidelines say that we can offer treatment at a CD4 count higher than 350, so it is an option. We are not going against current guidelines. It would just require a recommendation so that we could improve the public health of the city as well as possibly the individual benefit of the patient, because recent trials have shown that the actual individual patients benefit from being treated earlier. And hopefully decrease the transmission rate in the city.

Senator AKAKA. Thank you.

Dr. Vigilance, as elevated blood lead levels are especially dangerous in young children and cause developmental delays, what types of lead screening and treatment programs exist in D.C.?

Dr. VIGILANCE. Well, until last year, those activities did sit within the Department of Health, and now we work very closely with the Department of Environment to actually have those programs covered. So the children who need to be screened for lead are actually referred to their private providers and work with the Department of Environment to determine what is necessary for them moving forward, and they work very closely with a couple of the universities in the area regarding the lead in children specifically.

We recently provided some clinical guidance for parents who had questions about whether or not their children had been exposed as a result of an exposure that came up recently from some years ago and assisted in that regard by providing some basic guidelines for parents to follow. But the program itself no longer sits within the Department of Health.

Senator AKAKA. Dr. Vigilance, given the high rate of HIV/AIDS and chronic diseases in the District, some residents suffer from a combination of diseases, as Dr. Martins noted. How is DOH coordinating its HIV outreach and public campaigns with the other chronic disease initiatives?

Dr. VIGILANCE. So as Dr. Hader has mentioned, the data drives a lot more of what the Department of Health does now, and certainly having the Center for Policy, Planning, and Epidemiology now in my office, we are paying a great deal of attention to the data and what the data was telling us with respect to where to go.

I think that if you look at any map of the District with respect to the prevalence of poverty, the prevalence of tobacco use, the prevalence of HIV, the prevalence of homicide, those things are all overlaid there, very similarly distributed. And we can see that, using our data, we will need to be putting a number of different resources into some particular parts of the city. Without wanting to stigmatize any one particular area, basically either side of the river, Wards 5, 6, 7, and 8 typically bear the brunt of our chronic disease burden and our HIV burden, and HIV is becoming more, as Dr. Martins mentioned, a chronic disease.

So we have no choice but to coordinate our efforts, and I think that one of the things that is going on with respect to HIV and with respect to the Chronic Care Initiative (CCI), is that we are trying to move HIV testing away from the sort of community-based organization, only special event testing, into the regular routine medical encounter. And in doing that and by investing in the primary care settings that we are investing in with the tobacco settlement funds and by investing in the Chronic Care Initiative, which gets providers to think a little bit more holistically about their patients and not just think about the traditional boxes of chronic disease but add HIV and asthma and some other conditions to their list of concerns that they query patients about, we can do a better job of aligning providers with the needs that our patients actually have.

But that is the patient-provider conversation. There is a separate conversation that we are also having which relates to people and place, and this refers more to what we refer to as the "social determinants of health," those things that go into making communities healthy that are outside of the health care system. Since we understand that only about 15 to 25 percent of your health is a function

of the actual health care encounter, there are a number of other factors that go into you being healthy. They include, as mentioned before, availability of various resources, such as healthy food options, jobs, good education, etc. So we understand that we have to work more collaboratively with the school system, with Parks and Recreation, with the Mental Health Administration, and with other non-health agencies as well—businesses and non-government organizations, to create a bit more of a network where health and wellness is just the baseline as opposed to something that we are actually reaching for. We should understand that it is something that everybody needs to have at a bottom line, and that requires that we do a lot more in the way of collaboration. And we are reaching out to a number of partners to continue to do that, especially in the areas that are of greatest need in the city. Again, 5, 6, 7, and 8 are the wards of greatest concern, but we understand that across the city we have high rates of chronic diseases across the board, and we need to be looking at more than just those areas and more than just one particular socioeconomic and/or ethnic group.

Senator AKAKA. Dr. Vigilance, your testimony states that the DOH will seek funds to improve health information technology. Health Information Technology (IT) often requires a large up-front investment with the promise of improving efficiency and the quality of care over the long run. Additionally, health IT systems, which allow greater sharing of patient information among health professionals, must be implemented with great attention to protecting patients' privacy.

I would like to hear more about your plans for this initiative. What is the scope of the project in terms of the financial investment and patients who will be served?

Dr. VIGILANCE. Your question with respect to scope is timely and important, because health IT, as we typically discuss it, is placed in the box of the patient-provider conversation. So, appropriately, it refers to electronic medical records, personal health records, and health information exchange opportunities such as those involved in the regional health information organizations (RHIOs). We have a small RHIO here in the city. Six of our community health centers and two of our hospital emergency departments are involved in that activity, and it is important to make sure that we share information appropriately and make sure that people's privacy is maintained.

The stimulus package funds that are coming down through the American Recovery and Reinvestment Act (ARRA) will actually assist the District in being able to provide potentially set-up funds, as you mentioned, to some of those providers who are taking care of the Medicaid and Alliance population that we have here in the city. We would want to ensure that those providers, as well as others, have access to the start-up funds and the maintenance dollars potentially to be able to start an electronic medical record system within their practice and one that is interoperable and completely transparent, and at the same time highly secure.

We have recently had conversations with a number of partners, health care partners and business partners, around what exactly is the definition of health information technology for the District, and

we would like to take the conversation a little further than the traditional conversation has gone and start talking a little bit about tools that we can use on the technology side to assist people in managing their illnesses, managing their diseases; broadband access improvement so they actually have access to some of these many tools that are available on the Web, for example, because there is a digital divide that the city still very much lives in; and also helping people just gain access to information through a number of different technology applications that sit, again, outside of the patient-provider conversation.

And so we have the stimulus funds that have not come to the city yet, but there is an anticipation that there will be stimulus funds for the Medicaid and Alliance provider population, but we are also looking to invest some of our tobacco settlement funds in filling some of the holes that the stimulus package money is actually not going to fill because there were some specific eligibility criteria around those stimulus funds that may allow us to do certain things but not others, and we want to make sure that we cast a wide net and appropriately invest in health information technology that benefits people and providers, no matter where they are.

Senator AKAKA. Dr. Vigilance, the recent H1N1 outbreak has highlighted the need for pandemic preparedness. I have been impressed with the response so far at all levels of government. The District faces a particular challenge preparing for and responding to a potential disease outbreak. As our Nation's capital and a major hub for tourism, government, and business, the District could be a focal point for infectious disease transmission, and an outbreak in the District could disrupt government operations nationally.

What steps is DOH taking to respond to the H1N1 flu, and what preparation is ongoing to respond to any future wave of H1N1 infections?

Dr. VIGILANCE. So prior to H1N1 coming, and for some time now we have been involved in pandemic flu preparedness planning, and that has involved not only being able to effectively monitor the situation, quickly diagnose people, appropriately isolate them, if necessary, and provide them access to medical treatment, but also have the right staff on hand within the Department of Health and also within our partner population, if you will, in the National Capital Region to be sure to be able to have a timely response to any issues that come around.

We are fortunate in this region to have a very strong group that is involved in planning around issues that are related to all hazards, and we take an all-hazards approach to this situation. So the same sort of surge capacities, the same sort of disease surveillance activities would be what we would engage in no matter what the disease was.

The H1N1 situation allowed us to engage in real time with a number of different partners in the immediate area, and I think that one of the biggest lessons learned from that has been that our ongoing communications with our partners put us in a very good place to be able to react quickly and appropriately to the situation at hand.

There were some particular challenges that H1N1 provided with respect to school closures, and I think that is one area where, as

you have mentioned, the ability for a disease to actually create a situation that spills over into the everyday lives of people who are not actually infected with the disease is important to note, and the fact that we have such good relationships with the school system now made it very easy for us to get people onto conference calls quickly and make quick decisions about what to do about particular students in particular schools on particular days. And so we were fortunate to be able to do that, again, in part because of the ongoing conversations that we have on a regular basis.

We are not through H1N1 yet, but we are still monitoring that situation and had a stakeholders meeting last week to pull together a number of the people from the District who dealt with the situation and hear from them what exactly it is that we need to be doing better. We have had regular conference calls with our hospital partners. Our primary care partners are very well engaged with us. The emergency preparedness side of things with Homeland Security and Emergency Management, again, a strong partner with us, and has been with us from the beginning on this.

And so these ongoing communications allow us to mount a stronger and more unified response on a regular basis, and we are confident, never comfortable but confident, that we will be able to rise to the occasion if needed on a larger-scale basis.

For businesses, one thing that was important, we recognized the need to reach out to them early and to actually advise them on dusting off their continuation of operations plans, those plans that need to be put in place should, in fact, a good number of their staff are not able to come to work. We ourselves have those plans and have identified essential services as we instruct all businesses to do the same, so that if there is a situation where people have to stay home in large numbers, the business can continue as usual.

I am not sure that as a region we are necessarily there. We have not reached the destination of being completely prepared, but we are certainly moving in the right direction with respect to our Continuity of Operations (COOP) planning and, therefore, with respect to our pandemic planning as a whole. We hope to never have to necessarily enact the entire plan, but should we have to, then we think we are in pretty good shape.

Senator AKAKA. Thank you.

Dr. Martins, as you testified, in 2008 Whitman-Walker alone reported 541 new cases of HIV. This number, along with what we know from the behavior and epidemiology reports concerns me greatly. You provide several specific recommendations for addressing this epidemic. Given limited resources, what should be the top priorities for the District Government and for Congress?

Dr. MARTINS. I think when you are facing a large amount of the population being infected with HIV, with a certain number not knowing they are infected, the biggest thing is you want to get as much information as possible. So I think more collaborations and networks that we can get real-time information on people who are newly infected, resistance patterns, all those kind of data, having it come together.

One of the collaborations that will help us with that is called the DC Cohort, and that is a collaboration between NIH, the HIV/AIDS Administration, George Washington University (GWU), and a large

amount of the HIV providers. It is going to give us real-time numbers based on patient data. The data is going to be de-identified, but it is going to give us kind of real-time—where is the epidemic going and what are we doing that is effective? So especially when it comes to how are we going to change the epidemic, we want to know when it is effective immediately, not wait a year or two for data to know if we are doing a good job.

But I think if we are going to focus energies, I think it is on finding more information and on testing people more. I think that would be probably—at least the first place to kind of put all your money. And then from that standpoint on, my biggest push is to test people—I mean, to treat people with HIV medications earlier in their disease, and the main reason I push for that is the fact that we know—when we have looked at all the HIV studies trying to change behavior, none have been effective in reducing HIV or other STDs. And so I do not want to push everything into behavioral change models. I like the idea of using what we know about science to effect change and not just going back to the behavioral change models.

Senator AKAKA. Well, thank you. That is my last question for you as Chief Medical Officer.

Dr. Vigilance, I held a hearing in April during which the D.C. Chief Financial Officer projected that the District may have revenue shortfalls due in part to the recession. Reduced revenue will create pressures for budget reductions.

In this climate, how will the District address the health care needs of its residents? And what programs will be prioritized?

Dr. VIGILANCE. Sir, that is a great question, and I think we can look at this time as a period when the glass is half-full or a time when the glass is half-empty. The opportunity to do better work when you have less resources is obviously a challenge, but it is necessary. And I think that one of the things that we need to do a better job of within the Department of Health is defining exactly what are the most essential services and where are the areas of greatest impact for us, which is why when we discuss the three major things that affect the city with respect to health, we speak to obesity, we speak to infant mortality, and we speak to HIV. And having that focus on those three main areas that actually branch out into a number of other areas themselves, we can actually potentially be more efficient not only in our thought processes but also in our financial investments.

We are fortunate to be able to have some funding available to us to do capital development at the moment. We recognize that even though we do that capital development, we have to also change behaviors in order for people to make use of the facilities that we build. And that process in and of itself requires that we do better partnering.

So the first part of the answer to your question is that we have to actually focus ourselves a bit more specifically on some areas that may have gotten some focus before, but now require greater focus from us because of what they portend, what they lead us to; and then, second, to actually do a better job of partnering with potentially non-government agencies, be they private businesses or for-profit or nonprofit agencies that have reached into communities;

and, third, to do actually that, which is reach out to communities a bit more effectively and teach communities to actually be more able to do what they need to do to sustain and maintain their own health and wellness. I think providing people with those tools will require not only that we actually spend some time and resources, but that we actually make use of some of the resources that are already available within communities to get some of those things done. So those would be the three parts to the answer.

Senator AKAKA. Yes. My last question, of course, was on priorities. Dr. Hader, do you have anything to add to Dr. Vigilance's or Dr. Martins' responses regarding what the priorities should be for the District's HIV/AIDS initiatives given the limited resources?

Dr. HADER. Of course I do, and I will build on a few themes and add a little bit more.

First, to reiterate, testing, testing, testing, testing for HIV is absolutely the linchpin, and it is the linchpin for both prevention and better care and treatment outcomes. Testing is a prevention intervention. We know the vast majority of people, once they find out they are HIV positive, immediately take action to help prevent transmitting their infection to other people. It is estimated at a national level that at least half and up to 70 percent of new infections from HIV are transmitted from people who do not know they are positive. And so testing is prevention.

But where do we go from there? Care and treatment. We know that if people get immediately into care and treatment, that ongoing contact with a supportive care system not only can deliver information tools and messages for prevention on a consistent and repetitive basis, but we also suspect and hope, as Dr. Martins mentioned, the antiretroviral treatment itself by lowering viral load makes people less infectious.

A complement to that on the prevention side, though, is, I think, some of the basic shifts and scaled interventions that we are investing in as a priority do make a difference. First tools, having prevention tools available and available at the scale of our epidemic. And for us, those major tools include information—real, real, real information—condoms, and clean needles.

Second, it is actually addressing risk perceptions. We are in a paradigm shift, I think, in the District because of the better information and data we have. For a long time, I think, human nature is "HIV is everybody else's disease." I think with our new data that shows nearly every ward, nearly every group, nearly every age is affected by HIV. We can take that and run with that and say, it is a new world for risk perception. You do not have to have a whole lot of risky behavior in an environment that has got a lot of HIV out there to come in contact with HIV. So each individual needs to be aware that they are living in a risky environment.

And then, third—and I think this is a fundamental paradigm shift as well—is highlighting as part of our priorities that HIV is, in fact, not just about the individual; it is about relationships. It is about the individual and their romantic partners. It is about an individual and their family. It is about an individual and their communities. So if we can help to expand the conversation from not just "What do I do for me?" but "What do I do for the people I care about? What are the kind of difficult issues I need to grapple with

to keep the people I love safe, to keep myself safe? How do I support my partners, my friends, and families to make choices and decisions that will take us as a community to a better state for HIV and AIDS?" That is a cheap priority, but it is a really important one because it is one we cannot do just as the District Government ourselves. It requires absolute investment by all leaders across the board and all sectors in the District Government.

So we hope to stimulate and start those conversations for a paradigm shift that make all of our other services more effective.

Senator AKAKA. Well, thank you very much for that. I want to thank you again for your testimonies today. Based on your testimonies, we have learned a great deal about HIV/AIDS, chronic diseases, and other health challenges in the District, as well as the progress that has been made. I would encourage D.C. to continue its aggressive HIV testing campaign and to strengthen partnerships with organizations like Whitman-Walker Clinic.

This hearing has highlighted the need for effective communication not only within the D.C. Government but also within the community, and I must say that your responses have echoed that need. It is important that you move forward together as you work to improve the health of all D.C. residents.

The hearing record will remain open for 1 week during which time Members of the Subcommittee may submit additional questions.

Again, I want to thank you very much. Your testimonies have been helpful, and we look forward to your future success in this health program.

The hearing is adjourned.

[Whereupon, at 4:05 p.m., the Subcommittee was adjourned.]

APPENDIX

Public Health Challenges in the Nation's Capital

UNITED STATES SENATE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Subcommittee on Oversight of Government Management,

the Federal Workforce and the District of Columbia

THE HONORABLE DANIEL K. AKAKA, CHAIRMAN

THE HONORABLE GEORGE V. VOINOVICH, RANKING MEMBER

District of Columbia

Department of Health

PIERRE N.D. VIGILANCE, MD, MPH

DIRECTOR

TUESDAY, MAY 19, 2009

Chairman Akaka, Ranking Member Voinovich and distinguished subcommittee members, I am honored to testify before you today on Public Health Challenges in the Nation's Capital.

Public health prevents illness. Public health promotes wellness. Public health protects. Public health saves lives, and at this time when health care reform is front and center in our national policy arena, it is the missing link to the cost saving solutions needed to save our nation's health care system. Effective public health practice educates people, advocates for the conditions that promote wellness, links people to care, and provides access to treatment for those in need. I am pleased to present this public health testimony before you today as we discuss the public health challenges facing the District of Columbia.

I'd like to begin my remarks with an example of how public health protects and prevents. The District of Columbia Department of Health and our partners in emergency preparedness have been active in our response to the H1N1 influenza virus, working closely with the Homeland Security and Management Agency, the District of Columbia Hospital Center, and the Centers for Disease Control and Prevention to keep the public aware of the

situation, ensure that providers have up to date clinical guidance, and to provide timely reports on laboratory specimens collected from around the city. We are pleased with the coordination at all levels of government and the public sector in responding to this outbreak and repeatedly communicated the simple preventive strategy of washing your hands, covering your cough, and staying home if sick. Just last week the department hosted a stakeholders meeting with our local partners to discuss ways in which we could improve DC's response in case a similar situation were to arise in the future.

The DC DOH is an agency of 836 employees with an annual operating budget of $268M, comprising $137M in federal funds, $109M in local and special purpose revenue funds and $21M in intra-District funds. There are six administrations: Addiction Prevention and Recovery Administration, Community Health Administration, Center for Policy, Planning and Epidemiology, HIV/AIDS Administration, Health Emergency Preparedness and Response Administration, and Health Regulation and Licensing Administration. Annually we provide immunizations to over 3,600 people; last year we facilitated access to care in a network of community clinics that serve 93,000 people; we investigated 775 communicable disease cases,

removed 130,000 needles from the street through our needle exchange program, and inspected 388 health facilities.

The District boasts a high rate of health insurance relative to similar jurisdictions across the country. In spite of this, we still have poor health outcomes. Our epidemiology staff collects data that gives the city its vital signs, indicators of how well we are. Annually 3,000 people die from the top 5 preventable causes of death – heart disease, cancer, cerebrovascular disease (stroke), accidents and HIV/AIDS. The rate per 100,000 populations for cardiovascular disease is 239.0; for cerebrovascular disease (stroke) the rate is 35.0; HIV/AIDS is 32.9; homicide/assault is 29.0, and diabetes is 26.9.

The reasons for this are a combination of social and health factors including poverty, lack of education, unemployment, illiteracy, poor living conditions and other social inequity factors that influence access to resources. Part of our role is to identify these factors and play our part in reducing the negative effects that they can have. To do this we select specific targets, and collaborate with many partners. What I will describe for you relates to our current efforts aimed at reducing the city's chronic disease burden.

In the District, eight of the ten leading causes of death are in essence preventable. According to national health experts, chronic diseases such as heart disease, diabetes, stroke, and cancer can be prevented by access to screenings with appropriate linkages to treatment services, health education using behavioral models and frameworks, and systems level change in the allocation of resources and delivery of service. All of these prevention efforts can contribute to the improvement of health outcomes in the District.

At the request of City Council in 2007, the DOH developed a five year strategic plan entitled, "Working Together toward a Healthy Community, the D.C. Plan to prevent and Control Cardiovascular Diseases, Diabetes, and Kidney Diseases 2008 – 2013." The CDK plan was intended to be a working document that would serve as a tool for coordinating services to reduce disparities and improve the health of our residents.

Since the major causes of chronic kidney disease are high blood pressure and diabetes, DOH has funded programs to address risk factors such as blood pressure and blood glucose control. Examples include several Budget Support Act funded programs, namely the National Kidney Foundation of the National Capitol Area -- to implement the KEEP (Kidney Early Evaluation Program) screening program throughout the District.

Additionally, the Chronic Care Initiative was developed to build an enduring improvement initiative that will guide our city's service delivery system toward high-reliability, high-value, and high-quality care. Funded CCI programs incorporate many elements of the CDK Plan including system-wide coordination through the CCI coalition, conducting disease surveillance, improving the quality of health care and measuring success based upon several outcomes such as a reduction in hospitalizations and improvement in disease management metrics.

Obesity is a major contributing factor to many chronic diseases including hypertension (high blood pressure), cardiovascular disease (heart and blood vessel ailments), and stroke to name a few. Overall, 22% of adults in the District are obese and an additional 33% report being overweight. These numbers are even higher, nearly 42% and 40% in wards with higher prevalence of chronic disease. Youth in the District are at greater risks for obesity than children in the US with over 17.5% of DC public school students self reporting that they are obese. For 24 months, a work group comprised of community stakeholders, workforce managers, and healthcare providers have met to increase coordination throughout the District to combat the obesity epidemic. The department is now engaged in a series of community meetings to discuss the best obesity-reduction and prevention

options that our residents want to see in places where they live so that our obesity action plan can have a firm footing where it is needed most: the community.

Tobacco continues to be the number one preventable cause of death in the world, and things are no different here in the District where 3,000 people die from illnesses complicated by tobacco use annually. Tobacco disproportionately causes major health problems in our poorest communities which has caused us to invest heavily in recent years in tobacco cessation programs and media outreach to these communities. Over the last few years we have successfully collaborated with the American Lung Association of the District of Columbia (ALA-DC) to provide a comprehensive tobacco cessation program. Besides the media outreach, clients are provided access to nicotine replacement therapy, as well as "Quitline" - 1-800-QUIT-NOW. In 2008 we received 2,247 calls, and already in 2009 we have received 1,446 calls to gain access to the resources and support they need to quit smoking. Seventeen percent of adults and 10.5% of youth in the District report that they are a current smoker; however, our data indicates a five year trend of reductions in smoking reported by the Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Survey (YRBS). The combination of our cessation efforts through the Tobacco Free Families

Campaign, the ban on smoking fully implemented in 2007 and tobacco tax increases can all be credited for this reduction.

Public Health Investments

When the District securitized its tobacco settlement proceeds in 2006, the nearly $250 million in generated funds were all dedicated to public health. Initially the DC Council directed $49 million to cancer prevention and cancer patient support, tobacco cessation services, chronic disease, and health information technology. Over the last three years the tobacco cessation funds have been put to good use and worked in concert with other efforts as mentioned to reduce tobacco use. The Chronic Care Initiative born out of this investment will provide an opportunity for forward leaning continuous quality improvement activity that will engage the District's healthcare providers in a process aimed at improving the care they provide to their patients. To date our investment in health information technology has been in the establishment of a RHIO with six of the DCPCA-member clinics and two hospital-based Emergency Departments. In 2007 the District government invested $79 million of the funds to help stabilize Greater Southeast Community Hospital, now United Medical Center, through a transfer of ownership and major capital improvements.

An additional $1.5M was used to commission the Rand Corporation to produce the "Assessing Health and Health Care in the District of Columbia" report. The remaining funds (almost $140M) will be allocated according to the guidance provided by that report. We have established a grant program, called the Capital Health Project, which will disburse these funds into high impact health care capital developments and public health program investments in the neediest segments of the District.

In December of 2008, just three months after the funds became available, the Mayor and I announced the first round of grant awards totaling nearly $51 million. Focused primarily on primary and emergency care enhancements, $29,755,000 was awarded to the DC Primary Care Association for four primary care expansion projects in the Medical Home DC Initiative, which is designed to increase the access DC residents have to quality primary care sites. Additional investments include $10M to the Washington Hospital Center to enhance the capacity of one of our busiest trauma centers, and $11M to the United Medical Center to establish a Pediatric Emergency Department at their site east of the river in partnership with the Children's National Medical Center. These projects will go through an initial design and construction phase with these much needed new services slated to commence over the next one to three years.

DOH is currently reviewing applications from our second round of grants, which targeted additional primary care enhancement as well as the establishment of urgent care, something noticeably absent in the District. Up to $45 million is dedicated to this second round of grants.

Subsequently, DOH will develop grants to support health care development at the Hill East location, an important historical site in DC's health care system. Additional investments will be made in health information technology across the city's health care provider network, in school based health care capacity, and in prevention and wellness infrastructure.

Chronic Care Initiative

Over the past year, DOH has begun to grant funds for the Chronic Care Initiative to address major causes of mortality. The Chronic Care Initiative, a three year grant program funded by the tobacco settlement funds, is an innovative program designed to address the most common chronic diseases in the District. This $10 million continuous quality improvement initiative creates a consortium of academic, community, and government partners to bring about systems level change in the healthcare delivery system as well as behavioral change in communities with a disproportionate burden of disease. The consortium creates an environment for shared

learning and the CQI component allows for ongoing evaluation of program effectiveness that will inform future funding in the CCI and ensure that interventions lead to improved health outcomes in the long term.

To date, 12 initial grants have been awarded to address chronic disease at many levels including self-care education and support, transitions in care setting, language access with culturally appropriate care and capacity and coalition building. In addressing risk factors for chronic conditions, the initiative seeks to encourage clinical providers to include screening for smoking, hypertension, nutrition and kidney disease in routine visits as well as initiating worksite wellness projects, including wellness activities at DOH. The initiative also focuses on wellness by emphasizing improved access to healthy food choices in communities where such choices are lacking and high obesity rates are present.

Capital Health Project

For Round 3, DOH is preparing grant programs to support health care development at the Hill East location, for wellness and prevention capital programs, and school-based health. Subsequent efforts to enhance DC's health information technology is in the planning stages, however, we are doing so in conjunction with the planned federal investments arising from

the American Recovery and Reinvestment Act (ARRA) to ensure the most cost effective and complementary infrastructure investment for the District. The majority of these capital dollars will be awarded during FY2009. In FY2010, the focus of DOH's attention will be on effective grant monitoring and technical assistance of all grantees to ensure timely initiation, completion, and implementation of capital expansion projects.

American Recovery and Reinvestment Act

The Department of Health (DOH) will seek funds from ARRA distributed by the US Department of Health and Human Services (DHHS). The Department of Health's efforts will focus on funding aimed to ensure widespread implementation of interoperable electronic health records in community health centers and private practices (HIE/HIT), the expansion of HIE resulting in a regional health information organization (RHIO); enhancements to RHIO that aide in public health surveillance; and prevention and wellness activities such as the implementation of comprehensive infectious disease reduction strategies in concert with local health care facilities and community based initiatives, development of health empowerment zones, expansion of immunization program services and data collection activities, and expansion of the chronic care initiative programs.

ARRA funds will help to complete ongoing HIE efforts and create and maintain jobs in the health information systems sector. The implementation of community-based programs in health empowerment zones will create employment opportunities in health systems support such as community health workers, health/patient navigators and fitness and dietary instruction. In our efforts to continuously engage the community, DOH convened an ARRA educational session for healthcare stakeholders and will host additional sessions in the future.

DOH/DCPS Initiatives

The Department of Health and District of Columbia Public Schools (DCPS) collaborate closely on issues affecting District youth. DOH and DCPS are part of the School Health Work Group, which is comprised of senior level managers from multiple agencies within the District -- Department of Health, District of Columbia Public Schools, Department of Mental Health, Office of the State Superintendent of Education, Department of Health Care Finance, Office of the City Administrator, and the Office of the Deputy Mayor for Education. Through bi-weekly meetings, the work group coordinates health programs and activities for students across District agencies.

DOH also provides oversight for the District's school nursing program. This includes setting the expectations of school nurses, establishing standards and identifying health needs that must to be met for school enrollment. DOH works closely with the newly appointed DCPS Director of Health and Wellness. With guidance from DOH, this individual oversees the curricular aspects of health education for DCPS.

In addition to health education, more health related services are now being provided in the schools based on need. For example, over 40% of DC Public school students report being sexually active and nearly 30% report that they do not use condoms regularly. In response, in 2008 DOH piloted a STD screening program in one District public charter school. The program was based on a successful Philadelphia model. At present, plans are underway to include all high schools and the Summer Youth Employment Program (SYEP). During the 2008-2009 school years, DOH expanded to seven high schools; expansion will encompass all high schools in the coming school year. The rates of STDs in the schools have been found to be about 15 percent of those tested, with a current student participation rate of 85%.

There have been other programs and efforts related to inter-agency collaboration to protect our youth. As such, DC developed the Child Health

Action Plan, with DOH leading this effort. A copy of the plan can be found on the Department of Health's website: www.doh.dc.gov.

Lives will be saved by a more prevention-focused approach to health. The significant economic burden of disease requires that we pay particular attention to this important practice. All the efforts highlighted in this testimony are prevention-oriented, and we have a long way to go. More work needs to be done on policies that will impact the root causes of health problems, policies that take aim at diet and exercise reform in communities where the health disparities are most pronounced. More needs to be done to empower people to make better choices related to sex and food. More needs to be done to help people understand what they are at risk for. All our needs can be met by bringing public health to the discussion. From the classroom to the boardroom, we have a role to play, as we work to prevent disease, promote wellness and protect the public's health.

This concludes my prepared remarks and I am happy to answer any questions.

PUBLIC HEALTH CHALLENGES IN THE NATION'S CAPITAL

UNITED STATES SENATE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT,
THE FEDERAL WORKFORCE AND THE DISTRICT OF COLUMBIA

THE HONORABLE DANIEL K. AKAKA, CHAIRMAN
THE HONORABLE GEORGE V. VOINOVICH, RANKING MEMBER

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DEPARTMENT OF HEALTH

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DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH

MAY 19, 2009

Chairman Akaka, Ranking Member Voinovich and members of the Subcommittee, I am Shannon Hader, senior deputy director of the HIV/AIDS Administration in the District of Columbia Department of Health. I appreciate the opportunity to present testimony for your hearing -- "Public Health Challenges in the Nation's Capital" -- on the HIV/AIDS epidemic in the District of Columbia. My testimony will cover the highlights of our new statistics on HIV/AIDS; our current strategies and initiatives to prevent HIV transmission, make HIV testing routine and provide care and treatment for persons living with the disease; our partnerships with the community, including faith-based organizations; cooperation among government agencies; and the challenges and next steps to achieve our goal of reducing the burden of HIV and other sexually transmitted infections among District residents.

On March 15, 2009, the nation read the banner headline in *The Washington Post*: "HIV/AIDS Rate in D.C. Hits 3%; Considered a 'Severe' Epidemic, Every Mode of Transmission Is Increasing, City Study Finds." This was startling news to the public and truly a wake up call—information that empowers us to build and raise the District's response to match the scale and complexity of our "modern" HIV epidemic.

The *District of Columbia HIV/AIDS Epidemiology Update 2008* provides the most current statistics on the District's modern HIV/AIDS epidemic. Overall, 3 percent of all District residents are currently known to be living with HIV/AIDS. To put that in context, the U.S. Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) have historically defined an HIV epidemic as generalized

and severe when the overall percentage of disease among a population exceeds 1 percent. The numbers, however, reflect only the persons diagnosed with HIV/AIDS in the District. Other targeted studies show between one-third and one-half of residents who are already HIV-infected may be unaware of their infection. The true number of residents currently infected and living with HIV is certainly higher. In the District, nearly every population group, age and ward is experiencing a substantial epidemic.

Some populations are particularly impacted. Over 7% of persons between 40 and 49 years old are living with HIV/AIDS. Nearly 7% of African-American men have HIV. Every ward but one has HIV exceeding 1% of that ward's population. African-Americans are disproportionately affected, comprising 55% of our District's population but 78% of all HIV/AIDS cases. Though men still represent the larger proportion of cases at 70%, the number of women infected is increasing. In some wards of the city, the proportion is nearly half and half. Contrary to common misperception, HIV is not strictly a young person's disease. Over 70% of living HIV/AIDS cases are currently 40 or older. This number represents the combination of both people who are aging with HIV as well as those who are newly infected at older ages. In fact, we see nearly as many new diagnoses among persons who are 50 years old and older as among those who are under 30 years old.

The District also has one of the most complex epidemics in the world. Where most of the world may see one or two principal modes of transmission of HIV, in DC, all three major modes of transmission are at high levels. Among new cases, heterosexual contact is the

highest at nearly 40%, followed by sex between men who have sex with men at 25% and injection drug use at 15%.

The report not only presents the new findings on the impact of HIV/AIDS on District residents, it also highlighted the promising results of the District's efforts to reduce disease. The District's HIV testing programs have greatly increased early diagnosis among residents and reduced the number of babies born with HIV. In 2005, 10 babies were born with HIV. By 2007 only one baby was born with the infection. The report also confirms that the District has seen a 70-percent increase in the number of people tested with publicly supported testing from 40,000 in 2007 to over 70,000 in 2008. In fact, the District was just recognized by the CDC as one of the top three jurisdictions in the country in expanding HIV testing. DC nearly equaled New York City and the entire state of Florida in absolute numbers of persons tested and new HIV cases identified.

These achievements are not random; they are the mark of true committed leadership to reverse the epidemic in our city and it is truly a 'new day' in the District. Our Mayor Adrian Fenty released those new HIV/AIDS statistics as one demonstration of his leadership. No other mayor announces HIV/AIDS statistics. Mayor Fenty's leadership is not only shown in public events, such as holding the first ever Mayoral Summit on HIV/AIDS, but especially behind the scenes, in supporting new initiatives and directing interagency cooperation to achieve results. After 25 years of the epidemic, our Mayor is leading a new day with new opportunities.

In addition to new leadership, we have real data to drive our response to the epidemic. The 2007 Epidemiology Report and its 2008 Update boasted the most comprehensive and highest quality data ever collected and compiled on HIV/AIDS in our city. This data is already in practice in retooling our prevention strategies, routinizing HIV testing as part of a standard of health care and accelerating people entering care and treatment. The data has also galvanized our community, expanding traditional and non-traditional partnerships. The Effi Slaughter Barry Program, named in honor of our late First Lady, has provided technical assistance and start-up funding to more than 50 small community-based organizations to build their capacity to reduce HIV/AIDS in their neighborhoods.

We have described the complexity and breadth of the District's HIV/AIDS burden as a modern epidemic. Our modern epidemic requires a modern response. I can summarize this in Mayor Fenty's directives to me since I started in this position: go fast, go far and don't go it alone.

Go fast. The Mayor has repeatedly emphasized a clear urgency for our response. This urgent response must be marked by actions that are not just a flash in the pan, but are focused for a sustained and impactful response. For example, the District started an HIV testing campaign in 2006 to raise more awareness of HIV as well as new technology with a rapid oral test. The rapid test was easy to administer and gave a preliminary result in 20 minutes. This initiative has transitioned into a true, city-wide policy of routine HIV testing in our medical and community settings. Ultimately, we aim to make HIV as regular a test as blood pressure, blood sugar, cholesterol and other vital signs. One of our

major clinical partners, Unity Health Care, calls HIV the fifth vital sign. In our city where HIV is a common disease, the test must be a standard vital sign for every residents' health. And one test is not enough. We promote an annual HIV test.

Go far. The Mayor has directed us to bring the District's response to scale and impact. We are building on a strong foundation of sustainable systems that address HIV regularly and repeatedly as a major overriding health issue for the District. We are also putting the tools in place to monitor and evaluate that system to track our achievements over time. We are accountable for impact and effect.

Examples of core programs and results include the expanded testing achievements I mentioned earlier – making the District one of nation's leaders in HIV testing. We are also ramping up enrollment in our care and treatment programs. Through marketing and outreach, we increased enrollment in our AIDS Drug Assistance Program by 50% over an 18 month period to the highest level ever. Recently, through support of the Minority AIDS Initiative, our partners implemented a re-enrollment campaign to return people into primary medical care, medical case management, substance abuse services and mental health services. One provider was able, in a 4-month period, to re-enroll nearly 70% of clients who had been lost to follow-up over the previous 5 years.

We have substantially enhanced our youth services through our Youth and HIV Prevention Initiative. This year, we have increased four-fold the number of prevention programs funded focusing on young people.

We are reaching more residents with the tools to prevent transmission. The District is one of only two cities with a large public sector free condom distribution program. We have distributed over 1 million condoms in the past 6 months with a goal to reach 3 million free condoms each year. In addition, following the end of the Congressional ban on the use of our own local dollars to support needle exchange, we have implemented comprehensive harm reduction programs. The Mayor has committed nearly $700,000 to support community programs that in the first 6 months already enrolled 900 people into services, linked nearly 40% of them to detox and treatment services, and removed 130,000 needles from the street.

The District is breaking new ground in the country with innovative new programs. We funded the first couples testing initiative. For years, people who want to get tested with their spouse or partner have been told no. Now, in DC, we are planning to expand couples testing throughout the city as one strategy to promote further dialogue on relationships. Further, Parents Matter, an evidence-based intervention that trains parents to communicate with their pre-sexual initiation children, has been successful overseas but sadly un-utilized domestically. We are supporting Parents Matter among our foster parents and are training more community partners to expand the effective program. We have modeled these particular efforts on lessons learned from the PEPFAR program.

Don't go it alone. One of the cornerstones of our Mayor's directive is to build strong partnerships. Partnerships by definition recognize that an effective response to the HIV

epidemic requires mobilization of all community members. In terms of community partnerships and outreach, we have—as mentioned earlier—engaged more than 50 small organizations, many of which do not have HIV as their primary mission, to mainstream HIV/AIDS activities in their daily programming. We are expanding our faith-based partnerships through a Places of Worship Advisory Board, by recruiting more faith communities to include HIV in their day to day faith activities and by providing technical assistance and capacity building support, and have funded an umbrella organization to work with faith leadership of multiple denominations to take on the mantle of HIV. We are doing similar 'mainstreaming' of HIV knowledge and skills with non-health related youth serving organizations by providing capacity building and skills training assistance.

In terms of partnerships within government, our interagency collaborations have been expanded and formalized, and range among population and service need. With the DC Public Schools, we are partnering to develop new curriculum on sexual health and by training school nurses to counsel students. Though the number of young people with HIV/AIDS has doubled from 2001 to 2007, the prevalence rate is still lower compared to older populations. However, STD rates – namely chlamydia and gonorrhea – are very high. The District is one of only three cities to roll-out a voluntary school-based STD screening and treatment program designed to reach students who may not know they have an infection and to interrupt transmission. We offer sexual health information and urine-based testing for chlamydia and gonorrhea to high school students. To date, we report infection rates between 8% and 20%. The screening program is working. We went back to a few public charter schools in 2009 that we tested in 2008 and found a 34%

drop in infections. We have also collaborated with the Department of Employment Services to be the first city to offer free information and STD/HIV screening and treatment to young people in the Summer Youth Employment Program. Last year, we tested nearly 1,500 young people. This summer, we aim to expand that number to 5,000. One of the keys to this success has been partnerships among District Government agencies, including screening at Recreation Centers and with other agency sites. We are also working with the DC Department of Mental Health and the Addiction Prevention and Recovery Administration to address the critical co-morbidities of mental health and substance abuse services.

Our partnerships extend to innovations at the federal, academic and private levels. We are partnering with the National Institutes of Health, to increase local HIV prevention trials, build HIV sub-specialty capacity and services, and to better understand the successes and complications of persons in care and treatment in the District. We have also formed academic partnerships between our epidemiology bureau and The George Washington University, as well as the University and the Veteran's Administration with our TB Control Program. We also have formed new public-private partnerships with the Washington AIDS Partnership to develop an AIDS drug safety net, with the Gilead Foundation on school health curriculum development, the MAC AIDS Fund on female condom use and couples testing, and with the Global Business Coalition to make Washington, DC a model corporate partnership city.

This hearing also gives us the opportunity to engage your subcommittee on ways to improve the coordination between the federal government and the District to enhance impact on this epidemic. One extremely helpful action would be the coordination of federal supports for the local HIV response. Currently, in a given year, we receive between 10-14 core non-competitive public health grants for our HIV/AIDS, STD, TB and Hepatitis programs that span 5 to 7 different fiscal years. Each funding stream has a different application cycle, reporting cycle, reporting indicators, and none takes into account the overall impact and portfolio of activities in the District. The result of this fragmented system of federal management is an inordinate amount of time and duplicative paperwork to implement a non-fragmented response, and prevents our federal partners from seeing what it takes to achieve overall community-level impact. PEPFAR presents a model of federal coordination for impact and efficiency that preserves specific agency competencies and funding streams while ensuring that, taken as a whole, the overall funded portfolio makes sense.

Another opportunity to improve our coordination would be in sharing vital information. For example, the federal prison system does not convey health information on offenders returning to the District. In our correctional system, we have coordinated discharge planning among the DC Jail and our jail and community based health care provider. This coordination ensures continuity of care for persons living with HIV as well as appropriate prevention interventions for both returning individuals who are HIV positive and HIV negative. We lack this coordination with the federal system and are missing an opportunity to address important health needs of our returning residents.

We are not making this a platform for new federal funding for the District. However, there are clearly some opportunities through new investments to not just accelerate scale-up of our programs, but to 'catch up' and make up for lost time that brought us to the epidemic we have now. We have made specific supplemental requests to federal agencies that include the following:

- **Expanded HIV testing**. As mentioned earlier, the District was a high performer with expanded HIV testing, which was supported with CDC funding. The District has pending a request for a one-time investment of $4 million that would allow us to double the amount of testing in an 18 month period and maintain that performance afterwards.

- **Extended partner services**. The District was one jurisdiction that received funding from CDC that we used to begin to expand partner services for persons recently diagnosed with HIV and STDs. The District has been informed that we are ineligible for renewed funding of $825,000, as new restrictions have been applied to limit eligibility for the support to one year only.

- **Special Project**. The District currently has a pending request for a $500,000 Special Project of National Significance with HHS targeted to increasing care and treatment outcomes among HIV-infected women of color. These are available dollars and the District hopes that it can be one of the recipients.

- **1115 Medicaid Waiver.** The District has an 1115 Medicaid waiver that enables us to extend medical care and treatment to persons living with HIV/AIDS with matching local dollars. There are hundreds of persons eligible for coverage yet denied because the District has not to date received approval to raise the cap.

- **Needle Exchange.** The District does not seek additional funding from the federal government for needle exchange and harm reduction services, but lifting the federal ban would go far to allow community programs to eliminate the current burdensome administrative firewalls between federal and local funding sources that prevents relatively small investments of local funds build on current infrastructural investments from federal funds.

- **HOPWA formula.** The funding for the Housing Opportunities for People with AIDS (HOPWA) program is based on an outdated formula. HOPWA provides short-term and long-term rental assistance and housing supports. The formula is based on the total number of persons ever diagnosed with AIDS, including those who are no longer living. This approach disadvantages jurisdictions, such as DC, with larger numbers of living persons than deceased ones resulting in currently over 300 people on a waiting list for housing assistance. Formula reform would be very helpful in moving people from insecure to stable housing, which is crucial for maintaining their health.

The District may have the most complex epidemic in the country, but the current state of our epidemic is now emerging in other urban areas across the country. The increase in heterosexual contact is now surfacing in cities like Atlanta and Miami. Even within cities, there are communities where the epidemic is diversifying. Many urban areas have 'hot spots' within them that reflect similar patterns and challenges to what is seen city-wide in DC. So, turning the tide in the District is important as a model for other hot spots within urban areas.

In conclusion, we have reached that proverbial fork in the road. For years, the United States has been a leader overseas in reversing the course of the HIV/AIDS epidemic, while lacking in leadership for the domestic response. We can take the inspiration from international successes and model strategic plans designed to reach scale and impact in our cities, states, and rural areas. And we hope that the federal government will start in its backyard, here in our nation's capital. The District of Columbia assures you that its leadership, innovation and capacity are present to return the federal investment in our city and turn the corner for District residents on the HIV/AIDS epidemic.

WHITMAN-WALKER CLINIC™

May 19, 2009

TESTIMONY OF DR. RAYMOND CATARINO MARTINS BEFORE THE SENATE SUBCOMMITTEE ON OVERSIGHT OF GOVERNMENT MANAGEMENT, THE FEDERAL WORKFORCE, AND THE DISTRICT OF COLUMBIA "PUBLIC HEALTH CHALLENGES IN THE NATION'S CAPITAL"

Chairman Akaka, Senator Voinovich and Members of the Subcommittee, thank you for inviting me to testify at this hearing concerning Public Health Challenges in the Nation's Capital about the demographics of HIV/AIDS in the District, some of the current responses to HIV/AIDS in the District, and collaborative partnerships that relate.

Let me begin with some information about my professional experience. I am a primary care and HIV physician who lives in Ward 2 of the District, and have been the Chief Medical Officer for Whitman-Walker Clinic for the past 15 months. Through its two District health centers, Whitman-Walker Clinic provides much needed health care to the lesbian, gay, bisexual and transgender community, persons living with HIV, and others who face barriers to care. Our Elizabeth Taylor Medical Center is located in the northwest quadrant of the city and our Max Robinson Center is located east of the Anacostia River. Whitman Walker provides a primary medical home to more than 3000 HIV-positive patients. In 2008, 541 individuals were diagnosed with HIV by Whitman-Walker. Prior to this, I worked in private practice in the DC metropolitan area and at The George Washington University serving a predominantly gay, lesbian, transgender and HIV-positive clientele. These experiences, along with recent data and research results, form the basis of my comments.

My comments fall into three main categories: 1) The District should continue an aggressive HIV testing campaign; 2) The recommendations surrounding treatment for HIV should be analyzed and updated; and 3) Collaborations among health care providers and local and federal government should increase.

I. General Comments regarding the District of Columbia

The District of Columbia is in a truly unique situation with respect to HIV/AIDS as compared with other jurisdictions in the United States. The 2008 District of Columbia HIV/AIDS Epidemiology Update, released during February of 2009, found that 3% of District residents have been confirmed to be living with HIV. Unfortunately, random sampling research has shown that many more are likely to be HIV-positive and that the number infected with HIV is likely closer to 5% (National HIV Behavioral Surveillance Project 2001-2006). These numbers far exceed most cities within the United States.

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A major factor contributing to the unique situation of our city in comparison to other cities is the increased prevalence of HIV in multiple communities. Throughout the rest of the United States, Men Who Have Sex with Men (MSM) is the predominant mode of transmission for new HIV infections. Here in the District, heterosexual intercourse is the main mode of transmission at 36%, followed by MSM at 26%, and IV Drug Users at 13%. Washington, DC is the only major city in the United States where HIV is so pervasive in the heterosexual community.

Why is this the case? The 2001-2006 National HIV Behavioral Surveillance Project, Heterosexual Survey, a joint effort between the Centers for Disease Control, DC Department of Health (DOH), and The George Washington University, attempted to answer that question. That study demonstrated that heterosexual DC residents who are in "committed" relationships were often not monogamous, with 50% of the participants and 50% of their partners having sex outside of the relationship within the last year. This sex outside of the relationship along with lack of condom use (<30%) in a population with a high prevalence of HIV likely explain the increased incidence of HIV infections in the heterosexual community.

II. Specific Recommendations for the District of Columbia

- The District should continue an aggressive HIV testing campaign

First, individual behaviors are inherently difficult to change, as we are all human and fallible. My clinical experience reveals that, for so many individuals, sexual behaviors are even more challenging to alter than other behaviors since they are so instinctual and impulsive. A recent review of randomized clinical trials using behavioral interventions for HIV at-risk populations showed that although the study participants reported less sexual risk-taking behaviors, none have been shown to decrease the incidence of HIV or other sexually transmitted infections (Conference of Retroviruses and Opportunistic Infection, 2009, Symposium: Behavioral Intervention Trials).

I do not believe we should give up on education, prevention and behavioral change models, but I think it would be unwise to focus all resources solely on education and behavioral change. I rather postulate that we should rely on aggressive HIV testing strategies to identify everyone who is HIV-positive, and change clinical treatment strategies to lessen new infections. Everyone in the District should have routine HIV testing. HIV Opt-Out testing was started in 2007 by the DC DOH and has shown a great increase in the number of tests performed. The CDC has defined HIV opt-out testing as "performing HIV screening after notifying the patient that the test will be performed and the patient may elect to decline or defer testing. Assent is inferred unless the patient declines testing." Testing is recommended in all healthcare settings, and individuals should be screened at least annually. Perhaps the greatest success story to date has been the fact that with the push for HIV testing, we are catching people earlier in their disease. The average CD4 count (specific type of white blood cell that is destroyed during the course of HIV infection) at diagnosis in 2002 was 180 cells/ml, and in 2007 it was 332 cells/ml. This vast

improvement shows that the District is now diagnosing people with HIV, on average, before they develop AIDS and any associated complications.

- Re-evaluate HIV clinical guidelines regarding treatment – Using treatment as prevention

Clinically we need to reconsider current treatment guidelines for HIV medications. The CD4 count is important to understand for my recommendation for changing such guidelines. The average CD4 count of a patient without HIV is about 1000 cells/ml. Current treatment guidelines recommend following a patient with regular blood tests until their CD4 count falls below 350 cells/ml, and then to recommend initiating anti-retroviral therapy. During those years off medications, the patients often have a large amount of HIV in the blood, i.e., a high HIV viral load, and can easily infect others. Alternatively, if we treated patients with HIV medications soon after infection (at higher CD4 counts), their viral loads would be suppressed to very low levels much sooner and it would be more difficult for them to transmit HIV to someone else. Recent clinical trials, such as "Initiating rather than deferring HAART at a CD4 count greater than 500 is associated with improved survival" (New England Journal of Medicine, April 2009), have demonstrated clinical benefit for patients when starting HIV medications earlier. Therefore changing clinical guidelines to beginning anti-retroviral medications earlier in disease will benefit both the infected individual (with less HIV-related mortality) as well as the public health of the District (with likely less HIV transmission and new infections). This change in public health protocol will only work with a change in guidelines from the International AIDS Society, the Infectious Disease Society of America, the Department of Health and Human Services, and/or other government agencies. If that is not possible, there should be at least a recommendation specific to the District to offer HIV medications earlier to potentially curb new transmissions.

- Increase collaboration among health care providers and government within the District

Increased coordination among local institutions, the District government and the federal government provides additional opportunities to better leverage clinical knowledge and resources against the District's HIV epidemic. Whitman-Walker has been involved with the District's Department of Health and HIV/AIDS Administration, the National Institute of Health's National Institute of Allergy and Infectious Disease and National Institute on Drug Abuse, The George Washington University and other community health centers and universities. Many programs, such as the DC Center for AIDS Research, have focused on increasing grants for HIV clinical and basic research. One program that should have an immediate impact on the HIV epidemic is the DC Cohort. This collaboration between the DC HIV/AIDS Administration, The George Washington University, Cerner Corporation, and the major HIV providers in DC will allow the District to follow nearly 10,000 clients to better understand the HIV epidemic and the ongoing issues surrounding care, treatment, and survival. This project will incorporate best practices in data management and allow real-time evaluation of the HIV epidemic in the District. DOH

programs that have promising initial data include STD testing in high schools, needle exchange for IV drug users, and the HIV Opt-Out testing as I had mentioned earlier.

III. Conclusion/Closing

I strongly believe that one of the only ways we can change the course of the District's HIV epidemic is through a coordinated and aggressive response. Collaborations between local health authorities, universities and other research institutions, and community health centers and private practices will be critical. After the 2008 DC HIV/AIDS Epidemiology Update was released, there was some media attention to the increased HIV numbers, but this was quickly forgotten by a large majority of the public. There needs to be an aggressive media campaign so the public is frequently reminded of the severity of the issue along with a recommendation for everyone to be tested for HIV on a regular basis. Truly the solution to the epidemic is by identifying people who have HIV, and then by reducing HIV transmissions with early institution of therapy. By using the "Treatment as Prevention" strategy, patients will be started on HIV medications earlier in their disease and will be less likely to transmit to others. Through these programs, more individuals will be diagnosed with HIV and will need to be entered into clinical care. To handle caring for these patients, the District's HIV primary care infrastructure will need to be strong with expanded capacity for HIV testing and treatment.

Despite the complexity and costs associated with addressing the District's HIV epidemic, Whitman-Walker Clinic appreciates the leadership of the Subcommittee and remains committed to working closely with you and other agencies in solving this critical issue.

Sincerely,

Raymond Catarino Martins, M.D.
Chief Medical Officer
Whitman-Walker Clinic
Assistant Clinical Professor of Medicine
The George Washington University

BACKGROUND
PUBLIC HEALTH CHALLENGES IN THE NATION'S CAPITAL
MAY 19, 2009

BACKGROUND

The State of Public Health in the District of Columbia

The District faces a number of public health challenges, including an HIV/AIDS epidemic and a large portion of the population suffering from chronic diseases such as diabetes, kidney disease, and cardiovascular disease.[1] Data has shown that chronic non-infectious diseases like heart disease, diabetes, and hypertension are the major cause of death and illness among persons over the age of 45.[2]

There are many things that influence health challenges, including unsafe sexual practices, poor diet, and socioeconomic factors.[3] Prevention, testing, and diagnosis have not always been emphasized by the DC Department of Health (DOH).

HIV/AIDS IN THE DISTRICT

This section will examine District HIV/AIDS statistics and the steps that Mayor Fenty and the DC Department of Health are taking to curb transmission and increase treatment.

Two studies on DC HIV/AIDS were released in April 2009: the 2008 DC HIV/AIDS Epidemiology Update and the DC Behavior Study. Both provided sobering statistics on the scope of HIV/AIDS infections in District residents, with more than three percent of the population infected with HIV or AIDS, three times the percentage necessary to qualify as an epidemic.[4] The District has the highest rate of new AIDS cases in the United States – a rate that is 11 times the national average – and has the greatest increase in AIDS cases among people of color, women, injection drug users, and through heterosexual contact.[5] The majority of the population do not know their HIV status.[6]

In addition to the sheer numbers, the face of HIV has changed over the last three decades.[7] Currently, the highest rates of HIV are among residents aged 40 to 49 and among black men,

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[1] Carlos Cano, John O. Davis-Cole, & Fern Johnson-Clarke, *Vital Statistics of the District of Columbia*, (January 29, 2008), at 6, *available at* http://dchealth.dc.gov/doh/.
[2] *Id.* at 6.
[3] *Id.* at 7.
[4] Centers for Disease Control, *District of Columbia: Burden of Chronic Disease*, at 2 (2008).
[5] Pierre N.D. Vigilance, *District of Columbia HIV/AIDS Epidemiology Update 2008*, (February 2009), at 18, *available at* www.doh.dc.gov/hiv; Pierre N.D. Vigilance & Alan E. Greenberg, *District of Columbia HIV Behavior Study Series*, *available at* http://dchealth.dc.gov/doh/cwp/view,a,1371,q,604257.asp.
[6] Pierre N.D. Vigilance, *District of Columbia HIV/AIDS Epidemiology Update 2008*, (February 2009), at 18, *available at* www.doh.dc.gov/hiv; .
[7] *Id.*

with approximately seven percent of each of those populations already diagnosed and living with HIV.[8]

DC DOH and HAA Background

The HIV/AIDS Administration (HAA) established under the DC DOH focuses primarily on the following issues:

- Condom distribution and education
- Living with HIV
- Testing
- Counseling and Mental Health Services
- Medical Care
- Universal Perinatal HIV Testing and Treatment
- HIV Prevention Community Planning Group (HPCPG)
- DC AIDS Drug Assistance Program (ADAP)

DOH and HAA HIV/AIDS Initiatives

DC Condom Distribution Program

The Free Condom Distribution campaign aims to increase condom availability and education. Condom distribution has expanded from 115,000 condoms in 2006 to one million in 2007; its goal is to distribute three million free condoms per year.[9] The Program recruits community organizations, businesses and other locations to distribute free condoms.[10] Current partners include DC Snacks, the Mayor's Office on Latino Affairs, DOH, Addiction Prevention and Recovery Administration, Court Services and Offender Supervision Agency, STD clinic, DC Public Lab, Job Corps Center, Department of Public Works, and the Department of Mental Health.[11]

HIV Testing, Medical Care, and Emergency Services

According to the District's HIV/AIDS Epidemiology Report 2008, publicly-support HIV testing increased by 70 percent between 2007 and 2008.[12] HAA has successfully competed for CDC HIV Testing Expansion Grants. GW Hospital, Howard University Hospital, and Unity Healthcare have been allocated funding to implement routine emergency room HIV testing capabilities.[13] Additionally, the Administration provides funding to local health care providers

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[8] *Id.*

[9] *District of Columbia Department of Health HIV/AIDS Factsheet*, April 2009, at 1, *available at* http://www.dchealth.dc.gov/doh/frames.asp?doc=/doh/lib/doh/services/administration_offices/hiv_aids/pdf/condom_program_fact_sheet.pdf.

[10] *Id.*

[11] District of Columbia Department of Health HIV/AIDS Free Condom Locations, *available at* http://dchealth.dc.gov/doh/cwp/view,a,1371,q,603907.asp

[12] Vigilance, *supra* at 13.

[13] The Foundation for AIDS Research, *The Search for Lasting Solutions to HIV/AIDS*, (September 30, 2008), at 2.

who treat people living with HIV/AIDS. Services range from preventive and primary care to assisted living and hospice care.[14]

DC AIDS Drug Assistance Program

Under this program, low income underinsured and uninsured DC residents can receive HIV treatment for free.[15] The program is authorized under Title II of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.[16] The DOH has engaged in extensive media promotion to inform the public that HIV treatment is not always cost prohibitive.[17]

HIV Prevention Community Planning Group
The HPCPG will be responsible for determining which populations are in greatest need of HIV prevention services and the best ways to meet those needs.[18] The Administration, in turn, is responsible for implementing and funding programs and services that match the HPCPG's recommendations.[19]

This initiative builds off of the DOH's current efforts to form partnerships with faith-based organizations in hopes of reaching a larger section of DC residents, particularly those in the African-American community.[20]

Youth and HIV Prevention Initiative 2007- 2010

In an effort to expand its prevention efforts, the DC DOH introduced the "Youth and HIV Prevention Initiative 2007- 2010," focusing on six primary areas:

1. Innovative marketing technologies to raise awareness HIV/AIDS risk;
2. Increasing DC youth access to HIV testing;
3. Supporting on-going DC Public Schools (DCPS) efforts to teach HIV prevention education in schools;
4. Improving access to HIV prevention education and resources for high-risk youth who are not in school, e.g. drop-outs;
5. Providing resources, training and outreach necessary to reduce HIV stigma and expanding skills-building and support services for HIV positive youth;
6. Initiating and maintaining government and community partnerships and inter-/intra-governmental partnerships to coordinate HIV prevention efforts for youth.[21]

Whitman-Walker Clinic

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[14] District of Columbia Department of Health, *Comprehensive Plan for HIV Health and Support Services 2006-2008*, *see also* http://www.dchealth.dc.gov/doh/cwp/view,A,1371,Q,598629,dohNav_GID,1802,dohNav,|33200|34259|,.asp.

[15] *Id.*

[16] Ryan White Comprehensive AIDS Resources Emergency Act of 1990, P.L. 101-381, (1990).

[17] *Comprehensive Plan for HIV Health and Support Services 2006-2008, supra.*

[18] HIV Prevention Community Planning Group, *HPCPG Work Plan for 2009*, (April 12, 2007), *see also* http://www.dchealth.dc.gov/doh/cwp/view,a,1371,q,601184,dohNav_GID,1839,dohNav,|33815|,,.asp

[19] *Id.*

[20] *Id.*

[21] District of Columbia Department of Health, *Youth and HIV Prevention Initiative 2007- 2010*, (June 27, 2007), at 5.

The Whitman-Walker Clinic is a non-profit, community-based provider of health care that has served local residents for over 30 years.[22] The Clinic traditionally has been focused on providing culturally sensitive care to the gay, lesbian, bisexual and transgender (GLBT) community and people living with HIV/AIDS.[23] The Clinic has a staff of more than 100 and an operating budget of over $15 million.[24]

In response to demographic changes, increased need, and recent economic pressures, Whitman-Walker has expanded its scope of services, but also has had to consolidate its facilities and staff. Currently, the Clinic operates two facilities:[25]

- The Elizabeth Taylor Medical Center in Northwest DC, which provides primary care, eye care, x-ray and laboratory facilities, dental services, GLBT wellness, HIV testing and counseling, comprehensive HIV care, pre-natal and post-partum care, and clinical investigations;[26] and
- The Max Robinson Center in Southeast DC, which provides primary care, dental, mental health/addiction treatment, and day treatment for those living with HIV/AIDS.[27]

Whitman-Walker has faced significant financial shortfalls and as a result has sold a District property, closed its 20-year-old Northern Virginia clinic and a DC-based residential addictions treatment program, outsourced its pharmacy program, and laid off a significant number of staff.[28]

At the same time as this forced consolidation is occurring, Whitman-Walker is treating more patients than ever before at its remaining facilities– an estimated 10,000 in 2008.[29] The Clinic provides more than 13,000 anonymous and confidential HIV tests and counseling services annually.[30] The Clinic has continued to expand its client base and the range of health services it provides, including significant increases in the provision of medical care, mental health/addiction treatment, dental care, and legal services.[31] In addition, Whitman-Walker has shifted its funding model from private and government funding to public and private insurers by becoming a Federal Qualified Health Center (FQHC).[32]

CHRONIC DISEASES IN THE DISTRICT

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[22] Whitman-Walker Clinic, *Whitman-Walker 2006 Annual Report*; at 5, *see also* http://www.wwc.org/.
[23] *Id.* at 7.
[24] *Id.* at 11.
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] Whitman-Walker Clinic. *Whitman-Walker Clinic Announces 2009 Changes to Respond to Historic Economic Downturn, available at* http://www.wwc.org/news/2009changes.html.
[29] Mike DeBonis, *Clinical Depression: Economic Woes Land Whitman-Walker in Catania's Sights,* Washington City Paper, Vol. 29, at 5.
[30] Whitman-Walker Clinic, *supra.*
[31] Whitman-Walker Clinic, *News Release: Whitman-Walker Clinic Offers Community Update in the Fight Against HIV*, (January 28, 2009).
[32] *Id.*

Chronic diseases, such as heart disease, stroke, cancer, and diabetes, are among the most prevalent, costly, and preventable of all health problems in the District of Columbia.[33] In particular, cardiovascular diseases, diabetes, and kidney diseases (CDK) constitute a health care crisis in the District with its residents being afflicted at higher rates than the nation as a whole.[34] Almost one in three District residents suffers from some form of CDK, costing the District an estimated $2 billion dollars a year in medical expenditures alone. [35] The incidents of CDK and related cost are expected to increase significantly in the next several years.[36]

Background on Chronic Diseases and Common Risk Factors

Risk factors for chronic diseases include weight, nutrition, exercise, smoking, blood pressure, and cholesterol.[37] District youths exceed the national rates for three of four risk factors (weight, nutrition, and exercise), which suggests that the District may experience even higher rates of chronic disease in its future adult population.[38] District adults are near the national rates for the six risk factors and exceed the national rate of risk for high blood pressure.[39] Heart disease accounted for 28 percent of deaths in the District of Columbia, putting it well beyond the national average.[40]

In the District as well as nationwide, the prevalence of overweight people and obesity has dramatically increased, due in part to poor nutrition and physical inactivity.[41] In 2007, 55 percent of DC adults and 18 percent of youth were overweight or obese. Most adults (68 percent) and 81 percent of youths consumed fewer than five fruits and vegetables per day, and 46 percent of adults and 55 percent of youth were not engaging in regular moderate physical activity. [42] Chronic diseases and risk factors for those diseases disproportionately affect African-Americans and individuals with lower income levels.[43]

Current DC DOH initiatives

The District has taken significant steps during 2008 to establish new plans and initiatives to address the very serious effects of high proportions of chronic diseases on the residents of D.C. While it is too early to have any measurable outcomes from these new programs, the DC DOH

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[33] Centers for Disease Control, *supra*.
[34] *Id.*
[35] District of Columbia Department of Health. *Working Together Toward a Healthier Community: The District of Columbia Plan to Prevent and Control Cardiovascular Diseases, Diabetes, and Kidney Diseases 2008–2013*, at iv (2007).
[36] *Id.* at iv-v.
[37] *Id.* at 3.
[38] Centers for Disease Control, *supra* at
[39] *Id.* at 1-2.
[40] *Id.* at 2.
[41] *Id.* at 1.
[42] *Id.* at 2.
[43] *Id.* at 1-2.

plans to prevent and control cardiovascular diseases, diabetes, and kidney diseases include specific outcome measures for District residents to be reached by 2013.[44]

The results of the District's initiatives to prevent and control chronic diseases require close monitoring given the human and monetary cost of not addressing this health crisis for DC residents.[45] A combination of education, incentives to change lifestyle choices, and access to medical diagnosis and treatment are necessary to reverse the expected continued upward increase of those in the District at risk, living with, and dying from chronic diseases.[46]

The DC DOH is organized into seven administrations; each is responsible for a different aspect of District health such as addiction, HIV/AIDS, and community health.[47] The Community Health Administration's (CHA) mission is, in relevant part, to provide chronic and communicable disease prevention and control services.[48] Within the CHA are five bureaus that address key aspects of prevention including nutrition, infant and child health, primary care, and chronic disease.[49] Specifically, the Cancer and Chronic Disease Prevention Bureau is responsible for implementing cancer, diabetes, cardiovascular disease control and prevention initiatives, including the District's new Chronic Care Initiative.[50]

Chronic Care Initiative

The Chronic Care Initiative (CCI) began in October of 2008 with $10 million that was set aside by the DC City Council for chronic disease management of fatal illnesses and $250,000 from the Preventive Service Block Grant.[51] The initiative targets cardiovascular disease, hypertension, diabetes, chronic kidney disease, stroke, and chronic obstructive lung disease.[52] The goals of the initiative are:

1. To promote longer and healthier lives at each stage of illness, preventing the illness when possible; and
2. To deliver reliable, timely, evidence-based services for DC residents persons living with these conditions at lowest possible cost.[53]

As part of this overall initiative, the District also released a Cardiovascular Disease, Diabetes and Kidney Disease Plan in the fall of 2008 funded through a cooperative agreement with CDC to combat cardiovascular diseases, diabetes, and kidney diseases, the District of Columbia to

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[44] District of Columbia Department of Health. *Working Together Toward a Healthier Community: The District of Columbia Plan to Prevent and Control Cardiovascular Diseases, Diabetes, and Kidney Diseases 2008–2013*, *supra* at 22; *see also* attached Appendix.
[45] *Id.* at 22.
[46] *Id.*
[47] *Id.*
[48] District of Columbia Community Health Administration, *Organizational Chart*, at 1, *available at* http://www.doh.dc.gov/doh/cwp/view,a,3,q,573233,dohNav_GID,1825.asp
[49] *Id.*
[50] *Id.*
[51] District of Columbia Community Health Administration, *Chronic Care Initiative*, *available at* http://dchealth.dc.gov/doh/cwp/view,a,1374,q,603795,dohNav,%7C33139%7C.asp
[52] *Id.*
[53] *Id.*

coordinate the actions taken by all stakeholders.[54] This plan contains specific goals, objectives, and strategic actions to reduce illness and mortality from cardiovascular diseases, diabetes, and kidney diseases.[55] Broadly, this plan includes increasing testing, treatment, data collection, and lifestyle changes.[56]

Healthy People 2010

In addition, the District has continued work under its Healthy People 2010 plan.[57] Based on the U.S. Department of Health and Human Services initiative of the same name, the District began developing a plan in 2000 to significantly improve health outcomes by 2010.[58] The initiative has four priority areas: promote healthy behaviors; promote healthy and safe communities; improve access to quality health care services; and prevent and reduce diseases and disorders.[59] Thus, two of the priority areas – promoting healthy behaviors and preventing/reducing disease - include initiatives that would address risks and prevention of chronic illnesses.[60] Specifically, the District has taken steps to improve nutrition and weight as well as to prevent chronic diseases including diabetes and cardiovascular disease.[61]

The nutrition and weight component of DC's Healthy People 2010 has focused on women and children receiving WIC (Women, Infants, and Children) Program assistance in DC including goals to reduce iron deficiency, increase breastfeeding, and reduce obesity.[62] The promotion of healthy behaviors also includes efforts to reduce DC residents' use of tobacco, which is linked to many chronic diseases.[63]

The prevention of disease component of DC's Healthy People 2010 includes increasing the number of residents with high blood pressure who have it under control, increase to 100 percent the number of adults who have had their blood pressure checked within two years and know the results, reduce the mortality rate for residents who suffer strokes, increase the proportion of residents who regularly test their blood sugar, receive eye exams, and annually meet with a health provider on self-management strategies.[64] The prevention component also includes goals and objectives for asthma, cancer, HIV/AIDS and other diseases.[65]

DC DOH Nutrition Programs Administration Activities

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[54] District of Columbia Department of Health, *Working Together Toward a Healthier Community: The District of Columbia Plan to Prevent and Control Cardiovascular Diseases, Diabetes, and Kidney Diseases 2008–2013.*
[55] *Id.*
[56] *Id.*
[57] District of Columbia Department of Health. *Healthy People 2010 Plan 2005,* (2005).
[58] *Id.*
[59] District of Columbia Department of Health. *Healthy People 2010 Plan Mid-Course Correction 2005,* (2005).
[60] *Id.*
[61] *Id.*
[62] District of Columbia Department of Health. *Healthy People 2010 Biennial Implementation Plan (2006-2007),* (2006) at 7-18.
[63] *Id.*

[64] *Id.* At 90-95 & 100-103.
[65] *Id.* pp 67-141.

The Nutrition Programs Administration (NPA) plans, coordinates, advocates for, and assures access to high-quality nutrition programs and services as well as maximizes food and nutrition resources for the purpose of improving the health of District residents, with special emphasis on high-risk and disadvantaged populations. The NPA is responsible for the following programs:

- Commodity Supplemental Food Program (CSFP)
- Farmers' Market Nutrition Program (FMNP)
- Seniors Farmers' Market Nutrition Program (SFMNP)
- Special Supplemental Nutrition Program for Women, Infants and Children (WIC)[66]

NPA monitors the nutritional status of D.C. residents and it plans, develops, and coordinates initiatives to address problems.[67] NPA conducts citywide nutrition initiatives and community education programs, and works with a variety of public and private agencies on issues such as food security, fitness, childhood immunizations, and breast-feeding.[68]

Community Collaborative Initiatives

DC Obesity Work Group

The DC Obesity Work Group is comprised of city agencies and representatives of the District's business, health, and non-profit communities and is charged with creating the District's State Obesity Plan by September 2009.[69]

Men's Health Initiative

The Department of Health, in partnership with Pfizer, the Magic Johnson Foundation, and the National Basketball Association, has sponsored "Know Your Score," a men's health initiative. Know Your Score informs men about health screening, including glucose, cholesterol, blood pressure, and prostate cancer screening.[70] The Department of Health launched the initiative to encourage and promote healthier lifestyles for men and make available resources for the prevention and treatment of chronic disease.[71] The Know Your Score program uses a wallet-sized scorecard to record test results and explain each test and score.[72] Men can keep track of their scores, stay informed about their conditions, and discuss them with their health care providers.[73]

Selected School Health Initiatives

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[66] District of Columbia Department of Health Nutrition Programs Administration, *Mission, available at* http://app.doh.dc.gov/about/index_nps.shtm.
[67] *Id.*
[68] *Id.*
[69] Letter from Pierre N.D. Vigilance, (Feb. 24, 2009), *available at* http://doh.dc.gov/doh/frames.asp?doc=/doh/lib/doh/news_room/pdfs/director_wellness_letter.pdf
[70] District of Columbia Department of Health, *Men's Health Initiative, available at* http://app.doh.dc.gov/services/special_programs/mhi/index.shtm
[71] *Id.*
[72] *Id.*
[73] *Id.*

The District Department of Health and Public Schools are part of the School Health Work Group. Comprised of senior-level managers, the work group is charged with coordinating health activities for students across agencies through bi-weekly meetings.

DOH and DCPS also are part of the Interagency Collaboration and Services Integration Commission (ICSIC) team.[74] From the ICSIC process, DC developed the *Child Health Action Plan.*[75] DOH led this project with collaboration from several District agencies and stakeholders.[76] The action plan for fiscal years 2008 through 2010 addresses eight health indicators including obesity, asthma, substance abuse, and sexual health.[77] Relevant to chronic diseases, the plan aims to reverse the current trend in childhood obesity rates in DC by 2010 through improving nutritional options available to children and families, increasing physical activity of children using new physical education standards, and improving access to park and recreation programs.[78] In addition, the plan targets to reduce by 10 percent the current use of cigarettes, drugs, and alcohol among DC youth by building treatment capacity, using public information campaigns, and conducting at least 450 tobacco sales compliance inspections.[79]

In addition, all DC Public Schools and many DC public charter schools have adopted Local Wellness Policies (LWP).[80] These policies are a guide to improve student nutrition, physical activity, and overall wellness of DC students, which are critical risk factors for chronic disease.[81] Groups such as the local team of Action for Healthy Kids and DC School Wellness Work Group seeks to increase awareness and to improve the health and wellness of children in the District by facilitating the creation and promoting the use of policy improvements for District public and public charter schools.[82]

As discussed above, the DC Nutrition Programs Administration is working to improve information about and access to nutritious foods for the residents of the District.[83] In addition, initiatives to improve nutrition education, policies, and monitoring in the District's public schools may be a critical step in slowing or reversing the expected increase in incidents of chronic disease in DC.[84]

OTHER HEALTH CHALLENGES AND DISTRIC PREPAREDNESS

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[74] District of Columbia Department of Health, *Child Health Action Plan, (*2008), at 8, *available at* http://newsroom.dc.gov/show.aspx?agency=doh&section=2&release=12953&year=2008&file=file.aspx%2frelease%2f12953%2fchildhealthactionplan-FINAL3-07.pdf

[75] *Id.* at 2.

[76] *Id.*

[77] *Id.*

[78] *Id.* at 3.

[79] *Id.*

[80] Action for Healthy Kids, *District of Columbia Profile*, *available at* http://www.actionforhealthykids.org/state_profile.php?state=DC.

[81] District of Columbia Department of Health, *Child Health Action Plan*, *supra* at 8.

[82] *Id.* at 10.

[83] District of Columbia Department of Health Nutrition Programs Administration, *supra.*

[84] District of Columbia Department of Health. *Working Together Toward a Healthier Community: The District of Columbia Plan to Prevent and Control Cardiovascular Diseases, Diabetes, and Kidney Diseases 2008--2013*, *supra* at 25.

Lead Screening

The District has a universal screening law in place that requires all kids residing in the District to be tested for lead at least twice -- once between ages six and 14 months, and again between ages 22 and 26 months. Pediatricians are supposed to ask annually until age six years about each child's circumstances, in order to determine whether they may have moved into a higher risk category, in which case they should be screened again. Medicaid rules also require each Medicaid-enrolled child to be screened at one and two years of age. Medicaid providers and other pediatricians are responsible for providing the required blood lead tests, at the appropriate age, during well-child visits.

The District has a Childhood Lead Poisoning Prevention Program (CLPPP) that moved from the Department of Health to the Department of the Environment. The CLPPP is the District's repository for all lead screening data. All labs that analyze blood samples for lead are required to report test results to the CLPPP. For the past few years, CLPPP data show that 40 to 55 percent of all one-year-olds and 40 to 55 percent of all two-year-olds are getting screened in the District. According to the District, these results are similar to many jurisdictions nationwide.

The CLPPP has several ongoing projects to increase the District's screening rate for one- and two-year-olds, including: an agreement with school nurses to identify untested children for CLPPP follow up; a collaborative effort with DC Medicaid to identify unscreened children; increased case management and testing by CLPPP staff; a mobile testing vehicle to provide screening and outreach; providing free lead screenings for DC children at local daycare centers.

General Preparedness

This District has an array of response plans including the Pandemic Influenza Preparedness Plan and Bioterrorism Response Plan, both of which are integral parts of the District Response Plan (DRP). The District also maintains a website with health alerts on issues from pandemic information to food contamination announcements. It also publishes fact sheets on various health risks and issues in order to minimize some health risks and reduce the transmission of contagious conditions.

The DC DOH recently received $346,711 for vaccination of low-income residents in the District of Columbia from the stimulus package. DOH also will create an Adult Immunization Coordinator to ensure that the vaccines are being distributed and reaching the populations that otherwise would not have access to them.

The District has improved the rate of immunizations among children. Last month, the District of Columbia received the Highest Immunization Coverage Award for an Urban Area for 19-35 month olds from the CDC for its immunization rate of 85.4 percent compared to 77.2 percent nationally.

CONCLUSION

Mayor Fenty and the DC Government are aware of health challenges facing residents and have established health administrations and programs to target those challenges. By coordinating with DCPS to focus on healthy lifestyle choices and expand STD testing, the DOH hopes to create habits that will follow youth into adulthood and decrease many health risks.

While the DC Government's initiatives are encouraging, the data clearly show that there is still much work to be done, especially in the area of testing and treatment. As the District moves forward, it will be important for them to engage community stakeholders to reach as many residents as possible. General preparedness and vigilance regarding all health issues are also important parts of a balanced approach to safeguarding the health of DC residents. Changing the culture of healthcare in the District is not an easy task and only time will tell whether the DC's health initiatives take root.

KEY LEGISLATION:

- Ryan White Comprehensive AIDS Resources Emergency Act of 1990, P.L. 101-381.

RESOURCES:

Reports and Memoranda

- Carlos Cano, John O. Davis-Cole, & Fern Johnson-Clarke, *Vital Statistics of the District of Columbia*, (January 29, 2008), *available at* http://dchealth.dc.gov/doh/.
- Pierre N.D. Vigilance, *District of Columbia HIV/AIDS Epidemiology Update 2008*, (February 2009), *available at* www.doh.dc.gov/hiv.
- Pierre N.D. Vigilance & Alan E. Greenberg, *District of Columbia HIV Behavior Study Series*, *available at* http://dchealth.dc.gov/doh/cwp/view,a,1371,q,604257.asp.
- *District of Columbia Department of Health HIV/AIDS Factsheet*, April 2009, *available at* http://www.dchealth.dc.gov/doh/frames.asp?doc=/doh/lib/doh/services/administration_offices/hiv_aids/pdf/condom_program_fact_sheet.pdf
- The Foundation for AIDS Research, *The Search for Lasting Solutions to HIV/AIDS*, (September 30, 2008).
- District of Columbia Department of Health, *Comprehensive Plan for HIV Health and Support Services 2006-2008*, *see also* http://www.dchealth.dc.gov/doh/cwp/view,A,1371,Q,598629,dohNav_GID,1802,dohNav,|33200|34259|,.asp.

- HIV Prevention Community Planning Group, *HPCPG Work Plan for 2009*, (April 12, 2007), *see also* http://www.dchealth.dc.gov/doh/cwp/view,a,1371,q,601184,dohNav_GID,1839,dohNav,|33815|,,.asp.

- District of Columbia Department of Health, *Youth and HIV Prevention Initiative 2007-2010*, (June 27, 2007).

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Prepared Statement of
Paul Strauss, a United States Senator for the District of Columbia (Shadow)

Regarding Public Health Challenges in Our Nation's Capital

Chairman Akaka, and members of the Sub-Committee, I am Paul Strauss, an elected United States Senator for the District of Columbia. On behalf of my constituents, the disenfranchised citizens of the District of Columbia, I thank you for allowing me to present this statement for the record.

As a resident of the District and a representative of its citizens, I share the committee's concern regarding the current health status of DC's population. I am pleased that you, Senator Akaka, have used this Committee to begin a collaborative and constructive partnership with the District of Columbia institutions charged with protecting the public health of DC's residents and visitors. You have always been a leader in the effort to improve access to quality health care for indigenous people and minorities. For too long, Congress has been more interested in advancing its own agenda of social policy experiments, rather than looking at real scientific facts about our public health needs.

One of the more tragic instances of this Congressional malfeasance was the abuse of the Federal appropriations power to deny even the use of locally raised revenues to provide for critical programs to fight the spread of HIV and other blood borne contagions. Beginning in 1998, the funding for a highly successful needle exchange program was revoked and the program dismantled by the 105th Congress. They soon went a step further with the 1998 DC Appropriations Act, in which they banned the use of DC's own funds to support needle exchange programs. The 110th Congress finally repealed this ban in 2007, and it is impossible to ignore the corresponding drop from ten babies born with HIV during 2005, to only one born with HIV each of the last two years.

The results of the DC Department of Health HIV/Aids Epidemiology Update 2008 currently before us are disturbing. According to this most recent study, at least 3% of D.C. residents are living with HIV/AIDS. This rate is far higher than the 1% threshold required to constitute a "generalized and severe" epidemic according to the U.S. Centers for Disease Control and Prevention guidelines. Some have pointed to these statistics and argued that if the District were a country, its infection rate would place it 36th in the world.

Of course, if the District were a country, it would have sovereignty. With that sovereignty, it could have used its resources to address the health crisis as needed, instead of being forced to shut down lifesaving programs. It could have negotiated its own deals with drug manufacturers (as Canada has), to save its citizens money. As a sovereign country, it could have reformed its health insurance system years ago, instead of waiting for Congress to shake off the yoke of

insurance and pharmaceutical lobbyists who even today are working to prevent real change. The reality is that if the District were a not even a country, but just a sovereign state, it could have addressed this crisis head-on from the beginning, and been a national leader in this fight, not a victim of federal interference.

But sadly, the District is not a sovereign state, and the growth rate of HIV/AIDS, in spite of widespread efforts, continues to soar. The District has the highest rate of new AIDS cases per 100,000 people in the United States- a rate that is 11 times the national average. And, while it is clear the District has risen far beyond the level of action taken by cities comparable in size, more must be done to combat this deadly disease.

Thankfully, the role of the District's own Department of Health and other local government agencies in responding to this critical issue has been and continues to be exemplary. Because the District has been so forward-thinking in addressing the HIV/AIDS epidemic, it has necessarily magnified the visibility of the HIV/AIDS problem in DC. Though the number of reported HIV or AIDS cases in DC has increased alarmingly, a significant percentage of this increase is due to the dramatic rise in the number of people in the city being tested. This surge (an almost 70% increase from 2007 to 2008) is a direct result of the collaborative efforts of the DC Department of Health and various community groups across the District, including hospitals and emergency rooms.

The HIV/AIDS Administration in DC has moved quickly to promote awareness and expand aggressive testing of HIV/AIDS. This initiative began with widespread advertising and discussion encouraging individuals to get tested and "know their status." Free and anonymous testing, combined with continuing programs, such as regular HIV screening through the HIV Opt-Out program, have been very successful. (The Opt-Out program places the burden on the patient to opt-out of HIV/AIDS testing during checkups.) Other programs, designed to provide teenagers or other at-risk groups within the community with valuable information about sexual activity and methods of transmission, such as Metro TeenAIDS, are also helping to prevent HIV transmission. Additionally, officials, NGOs, and business owners have distributed 1.5 million free condoms to district residents in a cooperative effort to contain the spread of the virus. The willingness of DC officials to educate all people about this epidemic has taken them to elementary schools, nursing homes, and hospitals across the District. Because the AIDS virus crosses all racial, social, and economic barriers without prejudice, the District has taken not only aggressive, but sometimes unconventional paths to directly and effectively confront this grave problem.

Since the federal government lifted the ban on city funding of needle exchange programs in the District, these programs have been essential in the fight against HIV/AIDS. While needle exchange programs might appear contentious on the surface, they are recognized by the

American Medical Association, the American Psychiatric Association, the American Public Health Association, and the American Bar Association, among other credible agencies, as an effective means of combating HIV/AIDS transmission. The District of Columbia's 2007 HIV/AIDS epidemiology report cites injection drug use as the second most frequent mode of transmission, at the time accounting for 18.2% of living HIV/AIDS cases. The recent ban lift has enabled the District to allocate funding to continue these effective programs.

After increasing awareness and offering various methods of prevention, the final role of the local Department of Health is to protect those that have already contracted the virus and attempt to alleviate their suffering. Such programs have necessarily adjusted to include a 50% increase in the number of people living with HIV/AIDs and receiving free HIV medications. Further initiatives have led to the reduction in the number of babies born with HIV to a single case in each of the past two years. These figures are significantly down from ten babies born with HIV in 2005. Other proactive protection methods prescribe starting medical care and HIV medications as soon as an individual is diagnosed. Studies have shown that administering medications at the time of diagnosis increases the white blood cell count and greatly reduces the chance of transmission. This procedure has also been shown to significantly increase patients' longevity.

As a concerned citizen and elected official, I understand the importance of a quick, informed and strategic response to this health crisis. The public health programs in place within the District today, coupled with the combined recommendations in today's testimony, serve to establish just such a response. I wholeheartedly encourage Congress to not only support the course of action recommended by these local agencies with the praise given today from the dais, but with meaningful financial support. While we appreciate the importance of restraint from any interference with our implementation of these programs, as Congress did earlier when it banned the Needle Exchange program, mere non-interference is no longer enough. While it is entirely appropriate for the Federal Government to respect the admirable efforts of local agencies in battling this disease and providing valuable subject data for other communities faced with this battle, it is also crucial that Congress offer support and assistance to our local agencies in implementing these successful, if unconventional, programs.

The assistance of the Federal Government in providing funding and support of these solutions will be imperative to their unequivocal success. The lessons learned and strategies implemented in combating this problem in the District will be applicable and certainly beneficial to other large cities across the nation faced with a similar battle. Through collaboration with insurance providers, the Department of Health has already been able to reach 80,000 District residents through primary care physicians in 17,000 clinics. Substantially more citizens have been tested through two out of the six emergency rooms in the district, although the HIV/AIDs Administration hopes to expand this program to all emergency rooms in the next eighteen

months. An increase in funding now will directly result in increased testing initiatives, greater access to free medication, widespread education, and counseling training for medical staff to assist those already infected. Increased funding will translate into faster assessment and containment of this epidemic.

I thank you again for the opportunity to present this statement for the record, and on behalf of the citizens of the District of Columbia, to ask for Congress' assistance in fighting this battle. In closing, I would like to thank Ms. Kelly Hoecherl of my legislative staff for her assistance in preparing this statement. I would be happy to answer any questions that you or your staff might have.

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